



DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

This historical compilation on the Social Security Act and Amendments is provided specifically for the position of:

Regional Representative, HI, Atlanta, Georgia

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**SOCIAL SECURITY AMENDMENTS
OF
1965**

Volumes 1-5

**H. R. 6675
PUBLIC LAW 89-97**

Volume 5

AMENDMENTS TO THE RAILROAD RETIREMENT ACT (1965)

H. R. 10874

PUBLIC LAW 89-212

**REPORTS, BILLS,
DEBATES, AND ACTS**

**DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION**

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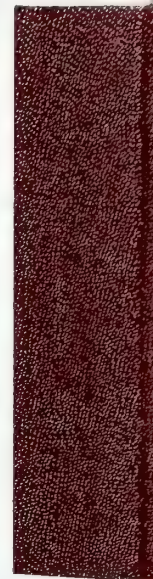
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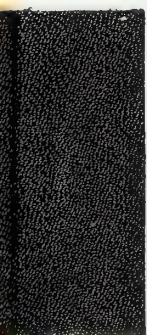
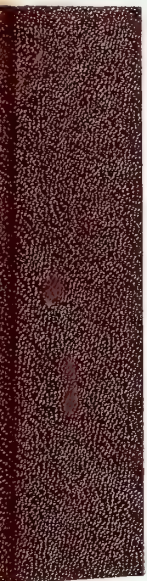
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SOCIAL SECURITY AMENDMENTS
OF 1965

REPORT

OF THE

COMMITTEE ON WAYS AND MEANS

ON

H.R. 6675

TO PROVIDE A HOSPITAL INSURANCE PROGRAM FOR
THE AGED UNDER THE SOCIAL SECURITY ACT WITH
A SUPPLEMENTARY HEALTH BENEFITS PROGRAM
AND AN EXPANDED PROGRAM OF MEDICAL ASSIST-
ANCE, TO INCREASE BENEFITS UNDER THE OLD-AGE,
SURVIVORS, AND DISABILITY INSURANCE SYSTEM,
TO IMPROVE THE FEDERAL-STATE PUBLIC ASSIST-
ANCE PROGRAM, AND FOR OTHER PURPOSES



MARCH 29, 1965.—Committed to the Committee of the Whole House on
the State of the Union and ordered to be printed

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SOCIAL SECURITY AMENDMENTS OF 1965

MARCH 29, 1965.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. MILLS, from the Committee on Ways and Means, submitted the following

R E P O R T

[To accompany H.R. 6675]

The Committee on Ways and Means, to whom was referred the bill (H.R. 6675) to provide a hospital insurance program for the aged under the Social Security Act with a supplementary health benefits program and an expanded program of medical assistance, to increase benefits under the old-age, survivors, and disability insurance system, to improve the Federal-State public assistance programs, and for other purposes, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

I. OVERALL PURPOSE AND SCOPE OF THE BILL

PURPOSE

The overall purpose of H.R. 6675 is as follows:

First, to provide a coordinated approach for health insurance and medical care for the aged under the Social Security Act by establishing—

(1) A basic plan providing protection against the costs of hospital and related care financed through a separate payroll tax and separate trust fund;

(2) A voluntary "supplementary" plan providing payments for physicians' and other medical and health services financed through small monthly premiums by individual participants matched equally by Federal Government revenue contributions; and

(3) A greatly expanded medical assistance program for the needy and medically needy which would combine all the vendor medical provisions for the aged, blind, disabled, and families with dependent children, now in five titles of the Social Security Act, under a uniform program and matching formula in a single new title.

Second, to expand the services for maternal and child health, crippled children, and the mentally retarded, and to establish a 5-year program of "special project grants" to provide comprehensive health care and services for needy children of school age or preschool age.

Third, to revise and improve the benefit and coverage provisions and the financing structure of the Federal old-age, survivors', and disability insurance system by—

(1) Increasing benefits by 7 percent across the board with a \$4 minimum increase for a worker retiring or who retired age 65 or older;

(2) Continuing benefits to age 22 for children attending school;

(3) Providing actuarially reduced benefits for widows at age 60;

(4) Liberalizing the definition and waiting period for disability insurance benefits;

(5) Paying benefits on a transitional basis to certain persons currently 72 or over who are now ineligible;

(6) Increasing the amount an individual is permitted to earn without losing benefits;

(7) Amending the coverage provisions by:

(a) Including self-employed physicians;

(b) Covering cash tips;

(c) Liberalizing the income treatment for self-employed farmers;

(d) Improving certain State and local coverage provisions;

(e) Exempting certain religious groups opposed to insurance;

(8) Revising the tax schedule and the earnings base so as to fully finance the changes made; and

(9) Making other miscellaneous improvements.

Fourth, to improve and expand the public assistance programs by—

(1) Increasing the Federal matching share for cash payments for the needy aged, blind, disabled, and families with dependent children;

(2) Eliminating limitations on Federal participation in public assistance to aged individuals in tuberculosis and mental disease hospitals under certain conditions;

(3) Affording the States broader latitude in disregarding certain earnings in determining need for aged recipients of public assistance; and

(4) Making other improvements in the public assistance titles of the Social Security Act.

SCOPE

The scope of the protection provided is broadly as follows:

Health insurance and medical care for the needy

(1) *Basic plan*.—It is estimated that approximately 17 million insured individuals and 2 million uninsured would qualify on July 1, 1966.

(2) *Voluntary Supplementary plan*.—It is estimated that of the total eligible aged of 19 million, from 80 to 95 percent would participate, which would mean approximately 15.2 to 18 million individuals would be involved.

(3) *Medical assistance for needy*.—The expanded medical assistance (Kerr-Mills) program is estimated to provide new or increased medical assistance to about 8 million needy persons during an early year of operation. States could, in the future, provide aid to as many as twice this number who need help with medical costs.

Old-age, survivors, and disability insurance

It is estimated that the number of persons affected immediately by changes in this title would be as follows:

<i>Provision</i>	<i>Number affected</i>
7-percent benefit increase (\$4 minimum in primary benefit) -----	20 million persons.
Child's benefit to age 22 if in school -----	295,000 children.
Reduced age for widows -----	185,000 widows.
Reduction in eligibility requirement for certain persons aged 72 or over -----	355,000 persons.
Liberalization of disability definition -----	155,000 workers and dependents.

Public assistance

It is estimated that some 7.2 million persons will be eligible for increased cash payments under the Federal-State matching programs. Moreover, it is estimated that 130,000 aged persons in mental and tuberculosis hospitals will potentially be eligible for payments because of the removal of the exclusion of these types of institutions from matching under the public assistance programs.

II. SUMMARY OF PRINCIPAL PROVISIONS OF THE BILL

A. HEALTH INSURANCE AND MEDICAL CARE FOR THE AGED

Your committee's bill would add a new title XVIII to the Social Security Act providing two related health insurance programs for persons 65 or over:

- (1) A basic plan in part A providing protection against the costs of hospital and related care; and
- (2) a voluntary supplementary plan in part B providing protection against the costs of physicians' services and other medical and health services to cover certain areas not covered by the basic plan.

The basic plan would be financed through a separate payroll tax and separate trust fund. The plan would be actuarially sound under conservative cost assumptions. Benefits for persons currently over 65 who are not insured under the social security and railroad retirement systems would be financed out of Federal general revenues.

Enrollment in the supplementary plan would be voluntary and would be financed by a small monthly premium (\$3 per month initially) paid by enrollees and an equal amount supplied by the Federal Government out of general revenues. The premiums for social security and railroad retirement beneficiaries who voluntarily enroll would be deducted from their monthly insurance benefits. Uninsured persons desiring the supplemental plan would make the periodic premium payments to the Government.

Your committee's bill would also add a new title XIX to the Social Security Act which would provide a more effective Kerr-Mills program for the aged and extend its provisions to additional needy persons. It would replace with a single uniform category the differing medical provisions for the needy which currently are found in five titles of the Social Security Act.

A description of these three programs follows:

1. BASIC PLAN—HOSPITAL INSURANCE, ETC.

General description.—Basic protection, financed through a separate payroll tax, would be provided by H.R. 6675 against the costs of inpatient hospital services, posthospital extended care services, posthospital home health services, and outpatient hospital diagnostic services for social security and railroad retirement beneficiaries when they attain age 65. The same protection, financed from general revenues, would be provided under a special transitional provision for essentially all people who are now aged 65, or who will reach 65 in the near future, but who are not eligible for social security or railroad retirement benefits.

Effective date.—Benefits would first be effective on July 1, 1966, except for services in extended care facilities which would be effective on January 1, 1967.

Benefits.—The services for which payment would be made under the basic plan include—

(1) inpatient hospital services for up to 60 days in each spell of illness with the patient paying a deductible amount of \$40 for each spell of illness; hospital services would include all those ordinarily furnished by a hospital to its inpatients; however, payment would not be made for private duty nursing or for the hospital services of physicians except services provided by interns or residents in training under approved teaching programs;

(2) posthospital extended care (in a facility having an arrangement with a hospital for the timely transfer of patients and for furnishing medical information about patients) after the patient is transferred from a hospital (after at least a 3-day stay) for up to 20 days in each spell of illness; 2 additional days will be added to the 20 days for each day that the person's hospital stay was less than 60 days (up to a maximum of 80 additional days)—the overall maximum for posthospital extended care could thus be 100 days in each spell of illness;

(3) outpatient hospital diagnostic services with the patient paying a \$20 deductible amount for each diagnostic study (that is, for diagnostic services furnished to him by the same hospital during a 20-day period); if, within 20 days after receiving such services, the individual is hospitalized as an inpatient in the same hospital, the deductible he paid for outpatient diagnostic services (up to \$20) would be credited against the inpatient hospital deductible (\$40); and

(4) posthospital home health services for up to 100 visits; after discharge from a hospital (after at least a 3-day stay) or extended care facility and before the beginning of a new spell of illness. Such a person must be in the care of a physician and under a plan established by a physician within 14 days of discharge calling for such services. These services would include intermittent nursing care, therapy, and the part-time services of a home health aide. The patient must be homebound, except that when certain equipment is used the individual could be taken to a hospital or extended care facility or rehabilitation center to receive some of these covered home health services in order to get advantage of the necessary equipment.

No service would be covered as posthospital extended care or as outpatient diagnostic or posthospital home health services if it is of a kind that could not be covered if it were furnished to a patient in a hospital.

A spell of illness would be considered to begin when the individual enters a hospital or extended care facility and to end when he has not been an inpatient of a hospital or extended care facility for 60 consecutive days.

The deductible amounts for inpatient hospital and outpatient hospital diagnostic services would be increased if necessary to keep pace with increases in hospital costs, but no such increase would be made before 1968. For reasons of administrative simplicity, increases in the hospital deductible will be made only when a \$5 change is called for and the outpatient deductible will change in \$2.50 steps.

Basis of reimbursement.—Payment of bills under the basic plan would be made to the providers of service on the basis of the “reasonable cost” incurred in providing care for beneficiaries.

Administration.—Basic responsibility for administration would rest with the Secretary of Health, Education, and Welfare. The Secretary would use appropriate State agencies and private organizations (nominated by providers of services) to assist in the administration of the program. Provision is made for the establishment of an Advisory Council which would advise the Secretary on policy matters in connection with administration.

Financing.—Separate payroll taxes to finance the basic plan, paid by employers, employees, and self-employed persons, would be earmarked in a separate hospital insurance trust fund established in the Treasury. The amount of earnings (wage base) subject to the new payroll taxes would be the same as for purposes of financing social security cash benefits. The same contribution rate would apply equally to employers, employees, and self-employed persons and would be as follows:

	Percent
1966.....	0.35
1967-72.....	.50
1973-75.....	.55
1976-79.....	.60
1980-86.....	.70
1987 and thereafter.....	.80

The taxable earnings base for the health insurance tax would be \$5,600 a year for 1966 through 1970 and would thereafter be increased to \$6,600 a year.

The schedule of contribution rates is based on estimates of cost which assume that the earnings base will not be increased above \$6,600. If Congress, in later years, should increase the base above \$6,600, the tax rates established can be reduced under the cost assumptions underlying the bill.

The cost of providing basic hospital and related benefits to people who are not social security or railroad retirement beneficiaries would be paid from general funds of the Treasury.

2. VOLUNTARY SUPPLEMENTARY INSURANCE PLAN

General description.—A package of benefits supplementing those provided under the basic plan would be offered to all persons 65 and over on a voluntary basis. Individuals who enroll initially would pay premiums of \$3 a month (deducted, where possible, from social security or railroad retirement benefits). The Government would match this premium with \$3 paid from general funds. Since the minimum increase in cash social security benefits under the bill for workers retiring or who retired at age 65 or older would be \$4 a month (\$6 a month for man and wife receiving benefits based on the same earnings record), the benefit increases would fully over the amount of monthly premiums.

Enrollment.—Persons who have reached age 65 before January 1, 1966, will have an opportunity to enroll in an enrollment period which begins on the first day of the second month after the month of enactment and ends March 31, 1966.

Persons attaining age 65 subsequent to December 31, 1965, will have enrollment periods of 7 months beginning 3 months before the month of attainment of age 65.

In the future, general enrollment periods will be from October to December 31, in each odd numbered year. The first such period will be October 1 to December 31, 1967.

No person may enroll more than 3 years after the close of the first enrollment period in which he could have enrolled.

There will be only one chance to reenroll for persons who are in the plan but drop out, and the reenrollment must occur within 3 years of termination of the previous enrollment.

Coverage may be terminated (1) by the individual filing notice during an enrollment period, or (2) by the Government, for nonpayment of premiums.

A State would be able to provide the supplementary insurance benefits its public assistance recipients who are receiving cash assistance if it chooses to do so.

Effective date.—Benefits will be effective beginning July 1, 1966.

Benefits.—The voluntary supplementary insurance plan would cover physicians' services, home health services, hospital services in psychiatric institutions, and numerous other medical and health services in and out of medical institutions.

There would be an annual deductible of \$50. Then the plan would cover 80 percent of the patient's bill (above the deductible) for the following services:

(1) Physicians' and surgeons' services, whether furnished in a hospital, clinic, office, in the home or elsewhere;

(2) Hospital care for 60 days in a spell of illness in a mental hospital with a 180-day lifetime maximum;

(3) Home health service (with no requirement of prior hospitalization) for up to 100 visits during each calendar year;

(4) Additional medical and health services, whether provided in or out of a medical institution, including the following:

(a) Diagnostic X-ray and laboratory tests, electrocardiograms, basal metabolism readings, electroencephalograms, and other diagnostic tests;

(b) X-ray, radium, and radioactive isotope therapy;

(c) Ambulance services; and

(d) Surgical dressings and splints, casts, and other devices for reduction of fractures and dislocations; rental of durable medical equipment such as iron lungs, oxygen tents, hospital beds, and wheelchairs used in the patient's home, prosthetic devices (other than dental) which replace all or part of an internal body organ; braces and artificial legs, arms, eyes, etc.

There would be a special limitation on outside-the-hospital treatment of mental, psychoneurotic, and personality disorders. Payment for such treatment during any calendar year would be limited, in effect, to \$250 or 50 percent of the expenses, whichever is smaller.

Administration by carriers: Basis for reimbursement.—The Secretary of Health, Education, and Welfare would be required, to the extent possible, to contract with carriers to carry out the major administrative functions relating to the medical aspects of the voluntary supplementary plan such as determining rates of payments under the

program, holding and disbursing funds for benefit payments, and determining compliance and assisting in utilization review. No contract is to be entered into by the Secretary unless he finds that the carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent. The contract must provide that the carrier take necessary action to see that where payments are on a cost basis (to institutional providers of service), the cost is reasonable cost. Correspondingly, where payments are on a charge basis (to physicians or others furnishing noninstitutional services), the carrier must see that such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the other policyholders and subscribers of the carrier. Payment by the carrier for physicians' services will be made on the basis of a receipted bill, or on the basis of an assignment under the terms of which the reasonable charge will be the full charge for the service.

Financing.—Aged persons who enroll in the supplemental plan would pay monthly premiums of \$3. Where the individual is currently receiving monthly social security or railroad retirement benefits, the premiums would be deducted from his benefits.

The Government would help finance the supplementary plan through a payment from general revenues in an equal amount of \$3 a month per enrollee. To provide an operating fund, if necessary, at the beginning of the supplementary plan, and to establish a contingency reserve, a Government appropriation would be available (on a repayable basis) equal to \$18 per aged person estimated to be eligible in July 1966 when the supplementary plan goes into effect.

The individual and Government contributions would be placed in a separate trust fund for the supplementary plan. All benefit and administrative expenses under the supplementary plan would be paid from this fund.

Premium rates for enrolled persons (and the matching Government contribution) would be increased from time to time if medical costs rise, but not more often than once every 2 years. The premium rate for a person who enrolls after the first period when enrollment is open to him or who reenrolls after terminating his coverage would be increased by 10 percent for each full year he stayed out of the program.

Medical expense deduction.—The health care provisions of your committee's bill have a relationship to the medical expense deductions allowed under the Internal Revenue Code. In the past the 3-percent limitation in the case of medical care expenses and the 1-percent limitation applied to expenditures for medicines and drugs were waived for persons 65 or over in recognition of the fact that medical expenses generally constituted a heavy financial burden for older people. In the past, however, there was no broad-coverage health insurance plan for older persons. The health insurance provisions of your committee's bill are designed to meet these problems in a generally comprehensive manner. The historical basis for the special medical expense provisions in the tax law for the relief of older taxpayers, therefore, no longer appears to exist. For this reason the bill provides that the 3-percent floor on medical expense deductions, as

well as the 1-percent limitation on medicines and drugs, is to apply to those age 65 or over in the same manner as it presently applies to those under age 65. This will have the effect of partially or fully recovering the \$3 monthly premium paid from general funds of the Treasury from those aged persons who have taxable income, depending on the amount of their taxable income.

To encourage the purchase of hospital insurance by all taxpayers, the bill provides a special deduction, available to those who itemize their deductions, for one-half of any premiums paid for insurance of medical care expenses whether or not they have medical expenses in excess of the 3-percent floor, but this deduction may not exceed \$250.

Another change limits the insurance premiums which may be taken into account to those which arise from coverage of medical care expenses. Still a further change treats as current, qualifying medical care expenses (subject to limitations) the prepayment before age 65 of insurance for medical care after age 65.

3. IMPROVEMENT AND EXTENSION OF KERR-MILLS MEDICAL ASSISTANCE PROGRAM

Purpose and scope.—In order to provide a more effective Kerr-Mills medical assistance program for the aged and to extend its provisions to additional needy persons, the bill would establish a single and separate medical care program to replace the differing provisions for the needy which currently are found in five titles of the Social Security Act.

The new title (XIX) would extend the advantages of an expanded medical assistance program not only to the aged who are indigent but also to needy individuals in the dependent children, blind, and permanently and totally disabled programs and to persons who would qualify under those programs if in sufficient financial need.

Medical assistance under title XIX must be made available to all individuals receiving money payments under these programs and the medical care or services available to all such individuals must be equal in amount, duration, and scope. Effective July 1, 1967, all children under age 21 must be included who would, except for age, be dependent children under title IV.

Inclusion of the medically indigent aged not on the cash assistance rolls would be optional with the States but if they are included comparable groups of blind, disabled, and parents and children must also be included if they need help in meeting necessary medical costs. Moreover, the amount and scope of benefits for the medically indigent could not be greater than that of recipients of cash assistance.

The current provisions of law in the various public assistance titles of the act providing vendor medical assistance would terminate upon the adoption of the new program by a State and must terminate no later than June 30, 1967.

Scope of medical assistance.—Under existing law, the State must provide "some institutional and noninstitutional care" under the medical assistance for the aged program. There are no minimum benefit requirements at all under the other public assistance vendor medical programs.

The bill would require that by July 1, 1967, under the new program a State must provide inpatient hospital services, outpatient hospital

services, other laboratory and X-ray services, skilled nursing home services, and physicians' services (whether furnished in the office, the patient's home, a hospital, a skilled nursing home, or elsewhere) in order to receive Federal participation. Coverage of other items of medical service would be optional with the States.

Eligibility.—Improvements would be effectuated in the program for the needy elderly by requiring that the States must provide a flexible income test which takes into account medical expenses and does not provide rigid income standards which arbitrarily deny assistance to people with large medical bills. In the same spirit the bill provides that no deductible, cost sharing, or similar charge may be imposed by the State as to hospitalization under its program and that any such charge on other medical services must be reasonably related to the recipient's income or resources. Also important is the requirement that elderly needy people on the State programs be provided assistance to meet the deductibles that are imposed by the new basic program of hospital insurance. Also where a portion of any deductible or cost sharing required by the voluntary supplementary program is met by a State program, the portion covered must be reasonably related to the individual's income and resources. No income can be imputed to an individual unless actually available; and the financial responsibility of an individual for an applicant may be taken into account only if the applicant is the individual's spouse or child who is under age 21 or blind or disabled.

Increased Federal matching.—The Federal share of medical assistance expenditures under the new program would be determined upon a uniform formula with no maximum on the amount of expenditures which would be subject to participation. There is no maximum under present law on similar amounts for the medical assistance for the aged program. The Federal share, which varies in relation to a State's per capita income, would be increased over current medical assistance for the aged matching so that States at the national average would receive 55 percent rather than 50 percent, and States at the lowest level could receive as much as 83 percent as contrasted with 80 percent under existing law.

In order to receive any additional Federal funds as a result of expenditures under the new program, the States would need to continue their own expenditures at their present rate. For a specified period, any State that did not reduce its own expenditures would be assured of at least a 5-percent increase in Federal participation in medical care expenditures. As to professional medical personnel used in the administration of the program, the bill would provide a 75-percent Federal share as compared with the 50-50 Federal-State sharing for other administrative expenses.

Administration.—The State agency administering the new program would have to be the same as that administering the old-age assistance program. As some States have done under existing law, such an agency could arrange for provision of medical care by or through the State health agency. The bill specifically provides as a State plan requirement that cooperative agreements be entered into with State agencies providing health services and vocational rehabilitation services looking toward maximum utilization of these services in the provision of medical assistance under the plan.

Effective date.—January 1, 1966.

4. COST OF HEALTH CARE PLANS

Basic plan.—Benefits and administrative expenses under the basic plan would be about \$1 billion for the 6-month period in 1966 and about \$2.3 billion in 1967. Contribution income for those years would be about \$1.6 and \$2.6 billion, respectively. The costs for the uninsured (paid from general funds) would be about \$275 million per year for early years.

Voluntary supplementary plan.—Costs of the voluntary supplementary plan would depend on how many of the aged enrolled.

If 80 percent of the eligible aged enrolled, benefit costs (and administrative expenses) of the supplementary plan would be about \$195 million to \$260 million in the last 6 months of 1966 and about \$765 million to \$1.02 billion in 1967. Premium income from enrollees for those years would be about \$275 and \$560 million, respectively. The matching Government contribution would equal the premiums.

If 95 percent of the eligible aged enrolled, benefit costs of the supplementary plan would be about \$230 to \$310 million in 1966 and about \$905 million to \$1.22 billion in 1967. Premium income from enrollees for those years would be about \$325 and \$665 million, respectively. The Government contribution would equal the premiums.

Public assistance plan.—It is estimated that the new program will increase the Federal Government's contribution about \$200 million in a full year of operation over that in the programs operated under existing law.

B. CHILD HEALTH AMENDMENTS

Maternal and child health and crippled children.—The bill would increase the amount authorized for maternal and child health services over current authorizations by \$5 million for fiscal year 1966 and by \$10 million in each succeeding fiscal year, as follows:

Fiscal year	Existing law	Under bill
1966	\$40,000,000	\$45,000,000
1967	40,000,000	50,000,000
1968	45,000,000	55,000,000
1969	45,000,000	55,000,000
1970 and after	50,000,000	60,000,000

The authorizations for crippled children's service would be increased by the same amounts.

The increases would assist the States, in both these programs, in moving toward the goal of extending services with a view of making them available to children in all parts of the State by July 1, 1975.

Crippled children-training personnel.—The bill would also authorize \$5 million for the fiscal year 1967, \$10 million for fiscal 1968, and \$17.5 million for each succeeding fiscal year to be for grants to institutions of higher learning for training professional personnel for health and related care of crippled children, particularly mentally retarded children and children with multiple handicaps.

Health care for needy children.—A new provision is added authorizing the Secretary of Health, Education, and Welfare to carry out a 5-year program of special project grants to provide comprehensive health care and services for children of school age, or for preschool

children, particularly in areas with concentrations of low-income families. The grants would be to State health agencies, to the State agencies administering the crippled children's program, to any school of medicine (with appropriate participation by a school of dentistry), and any teaching hospital affiliated with such school, to pay not to exceed 75 percent of the cost of the project. Projects would have to provide screening, diagnosis, preventive services, treatment, correction of defects, and aftercare, including dental services, with treatment, correction of defects, and aftercare limited to children in low-income families.

An appropriation of \$15 million would be authorized for the fiscal year ending June 30, 1966; \$35 million for the fiscal year ending June 30, 1967; \$40 million for the fiscal year ending June 30, 1968; \$45 million for the fiscal year ending June 30, 1969; and \$50 million for the fiscal year ending June 30, 1970.

Mental retardation planning.—Title XVII of the act would be amended to authorize grants totaling \$2,750,000 for each of 2 fiscal years—the fiscal year ending June 30, 1966, and fiscal year ending June 30, 1967. The funds would be available during the 3-year period July 1, 1965, to June 30, 1968. The grants would be for the purpose of assisting States to implement and followup on plans and other steps to combat mental retardation authorized under this title of the Social Security Act.

C. OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE AMENDMENTS

1. BENEFIT CHANGES

(a) *7-percent across-the-board increase in old-age, survivors, and disability insurance benefits*

The bill provides a 7-percent across-the-board benefit increase, effective retroactively beginning with January 1965, with a minimum increase of \$4 for retired workers at age 65. These increases will be made for the 20 million social security beneficiaries now on the rolls.

Monthly benefits for workers who retire at or after 65 would be increased to a new minimum of \$44 (now \$40) and to a new maximum of \$135.90 (now \$127). In the future, creditable earnings under the increase in the contribution and benefit base to \$5,600 a year (now \$4,800) would make possible a maximum benefit of \$149.90.

The maximum amount of benefits payable to a family on the basis of a single earnings record would be related to the worker's average monthly earnings at all earnings levels. Under present law, there is a \$254 limit on family benefits which operates over a wide range of average monthly earnings. Under the bill, until 1971, the highest family maximum would be \$312.

Under the second-step increase in the wage base to \$6,600 to be effective in 1971, also provided in the bill, the worker's primary benefit would range from a minimum of \$44 to a future possible maximum of \$167.90 a month. Maximum family benefits up to \$368 would also be payable.

(b) *Payment of child's insurance benefits to children attending school or college after attainment of age 18 and up to age 22*

H.R. 6675 includes the provision adopted by both House and Senate last year which would continue to pay a child's insurance benefit

until the child reaches age 22, provided the child is attending a public or an accredited school, including a vocational school or a college, as a full-time student after he reaches age 18. Children of deceased, retired, or disabled workers would be included. No mother's or wife's benefits would be payable if the only child in the mother's care is one who has attained age 18 but is in school.

This provision will be effective January 1, 1965. It is estimated that 295,000 children will be able to receive benefits for a typical school month in 1965 as a result of this provision.

(c) Benefits for widows at age 60

The bill would provide the option to widows of receiving benefits beginning at age 60, with the benefits payable to those who claim them before age 62 being actuarially reduced to take account of the longer period over which they will be paid. Under present law, full widow's benefits and actuarially reduced worker's and wife's benefits are payable at age 62.

This provision, adopted by both Houses of Congress last year, would be effective for the second month after the month of enactment. It is estimated that 185,000 widows will be able to get benefits immediately under this provision.

(d) Amendment of disability program

(i) *Definition.*—H.R. 6675 would eliminate the present requirement that a worker's disability must be expected to result in death or to be of long-continued and indefinite duration, and instead provide that an insured worker would be eligible for disability benefits if he has been totally disabled throughout a continuous period of at least 6 calendar months. Benefits payable by reason of this change would be paid for the second month following the month of enactment.

(ii) *Payment period.*—The period during which an individual must be under a disability prior to entitlement of benefits is reduced by 1 month under the bill. Disability benefits would be payable beginning with the last month of the 6-month waiting period rather than with the first month after the 6-month waiting period as under existing law. This change would be applicable to all cases in which the last month of the waiting period occurs after the month of enactment.

It is estimated some 155,000 disabled workers and dependents will be benefited by these provisions.

Certain changes are also made in the provision terminating disability benefits and waiving subsequent waiting periods so as to make them more restrictive when applied to shorter term disabilities.

(iii) *Entitlement to disability benefits after entitlement to benefits payable on account of age.*—Under the bill, a person who becomes entitled before age 65 to a benefit payable on account of old age could later become entitled to disability insurance benefits.

(iv) *Allocation of contribution income between OASI and DI trust funds.*—Under the bill, an additional one-fourth of 1 percent of taxable wages and three-sixteenths of 1 percent of taxable self-employment income would be allocated to the disability insurance trust fund, bringing the total allocation to three-fourths of 1 percent and nine-sixteenths of 1 percent, respectively, beginning in 1966.

(e) Benefits to certain persons at age 72 or over

Your committee's bill adopts a provision approved by the House and Senate last year, which would liberalize the eligibility requirements by providing a basic benefit of \$35 at age 72 or over to certain persons with a minimum of three quarters of coverage acquired at any time since the beginning of the program in 1937. To accomplish this, a new concept of "transitional insured status" is provided. Present law requires a minimum of six quarters of coverage in employment or self-employment.

(i) *Men and women workers.*—The concept of "transitional insured status" which would make an individual eligible for an old-age or wife's benefit provides that the oldest workers will receive benefits with only three quarters of coverage, under the bill. These three quarters may have been acquired at any time since the inception of the program in 1937. For those who are not quite so old, the quarters of coverage requirement would increase until the requirement merges with the present minimum requirement of six quarters.

The following table illustrates the operation of the "transitional insured status" provision for workers.

*Transitional insured status requirements with respect to workers benefits*¹

Men		Women	
Age (in 1965)	Quarters of coverage required	Age (in 1965)	Quarters of coverage required
76 or over	3.	73 or over	3.
75	4.	72	4.
74	5.	71	5.
73 or younger	6 or more.	70 or younger	6 or more.

¹ Benefits will not be payable, however, until age 72.

(ii) *Widows.*—Any widow who is age 72 or over in 1966, if her husband died or reached age 65 in 1954 or earlier, could get a widow's benefit if her husband had at least three quarters of coverage. Present law requires six quarters.

If the husband died or reached 65 in 1955, the requirement would be four quarters. If he died or reached 65 in 1956, the requirement would be five quarters. If he died or reached 65 in 1957 or later, the minimum requirement would be six quarters, the same as present law.

For widows reaching age 72 in 1967 and 1968, there is a "grading-in" of the quarters of coverage requirement; which would be four or five quarters of coverage, respectively. Widows reaching age 72 in 1969 or after would be subject to the requirements of existing law of six or more quarters of coverage.

The table below sets forth the requirements as to widows:

Transitional insured status requirements with respect to widow's benefits

Year of husband's death (or attainment of age 65, if earlier)	Present quarters required	Proposed quarters required for widow attaining age 72 in—		
		1966 or before	1967	1968
1954 or before	6	3	4	5.
1955	6	4	4	5.
1956	6	5	5	5.
1957 or after	6 or more	6 or more	6 or more	6 or more.

(iii) *Basic benefits.*—Men and women workers who would be eligible under the above-described provisions for workers would receive a basic benefit of \$35 a month. A wife who is aged 72 or over (and who attains that age before 1969) would receive one-half of this amount, \$17.50. No other dependents' basic benefits would be provided under these provisions.

Widows would receive \$35 a month under the above-described provision.

These provisions would become effective for the second month after the month of enactment, at which time an estimated 355,000 people would be able to start receiving benefits.

(f) *Retirement test*

H.R. 6675 liberalizes the social security earned income limitation so that the uppermost limit of the "band" of a \$1 reduction in benefits for each \$2 in earnings is raised from \$1,700 to \$2,400. Under existing law the first \$1,200 a year in earnings is wholly exempted, and there is a \$1 reduction in benefits for each \$2 of earnings up to \$1,700 and \$1 for \$1 above that amount.

Your committee's bill would increase the \$1 for \$2 "band" so that it would apply between \$1,200 and \$2,400, with \$1 for \$1 reductions above \$2,400. This change is effective as to taxable years ending after 1965.

The bill also exempts certain royalties received in or after the year in which a person reaches age 65 from copyrights and patents obtained before age 65, from being counted as earnings for purposes of this test, effective as to taxable years beginning after 1964.

(g) *Wife's and widow's benefits for divorced women*

Your committee's bill would authorize payments of wife's and widow's benefits to the divorced wife aged 62 or over of a retired, deceased, or disabled worker if she had been married to the worker for at least 20 years before the date of the divorce and if her divorced husband was making (or was obligated by a court to make) a substantial contribution to her support when he became entitled to benefits, became disabled, or died. H.R. 6675 would also provide that a wife's benefits would not terminate when the woman and her husband are divorced if the marriage has been in effect for 20 years. Provision is also made for the reestablishment of benefit rights for a widow or a wife who remarries and the subsequent marriage lasts less than 20 years. These changes are effective for the second month following the month of enactment.

(h) *Adoption of child by retired worker*

Your committee's bill would change the provisions relating to the payment of benefits to children who are adopted by old-age insurance beneficiaries to require that, where the child is adopted after the worker becomes entitled to an old-age benefit, (1) the child must be living with worker (or adoption proceedings have begun) in or before the month when application for old-age benefits is filed; (2) the child must be receiving one-half of his support for the entire year before the worker's entitlement; and (3) the adoption must be completed within 2 years after the worker's entitlement.

2. COVERAGE CHANGES

The following coverage provisions were included :

(a) *Physicians and interns*

Self-employed physicians would be covered for taxable years ending after December 31, 1965. Interns would be covered beginning on January 1, 1966.

(b) *Farmers*

Provisions of existing law with respect to the coverage of farmers would be amended to provide that farm operators whose annual gross earnings are \$2,400 or less (instead of \$1,800 or less as in existing law) can report either their actual net earnings or 66⅔ percent (as in present law) of their gross earnings. Farmers whose annual gross earnings are over \$2,400 would report their actual net earnings if over \$1,600, but if actual net earnings are less than \$1,600, they may instead report \$1,600. (Present law provides that farmers whose annual gross earnings are over \$1,800 report their actual net earnings if over \$1,200, but if actual net earnings are less than \$1,200, they may report \$1,200.)

(c) *Cash tips*

Coverage of cash tips received by an employee in the course of his employment as wages would be provided, effective as to tips received after 1965.

(i) *Reporting of tips.*—The employee would be required to report to his employer in writing the amount of tips received and the employer would report the employee's tips along with the employee's regular wages. The employee's report to his employer would include tips paid to him through the employer as well as those received directly from customers of the employer. Tips received by an employee which do not amount to a total of \$20 a month in connection with his work for any one employer would not be covered and would not be reported.

(ii) *Tax on tips.*—The employer would be required to withhold social security taxes only on tips reported by the employee to him. Unlike the provision in last year's House bill, this provision requires the employer to withhold income tax on such reported tips.

The employer would be responsible for the social security tax on tips only if the employee reported the tips to him within 10 days after the end of the month in which the tips were received. The employer would be permitted to gear these new procedures into his usual payroll periods. The employer would pay over his own and the employee's share of the tax on these tips and would include the tips with his regular reports of wages. If at the time the employee report is due (or, in cases where the report is made earlier—if between the making of the report and the time it is due), the employer does not have unpaid wages or remuneration of the employee under his control sufficient to cover the employee's share of the social security tax applicable to the tips reported, the employee will pay his share of the tax with his report.

If the employee does not report his tips to his employer within 10 days after the end of the month involved, the employer would have no liability. In such a case the employee alone would be liable not

only for the amount of the employee tax but also an additional amount equal to the employee tax.

For purposes of withholding income tax on tips, the employer is required to deduct and withhold only on the tips reported to him and only to the extent that the tax can be deducted and withheld before the close of the calendar year from wages (excluding tips, but including funds turned over to the employer by the employee for such purpose) under the control of the employer.

(d) State and local government employees

Several changes made by the bill would facilitate social security coverage of additional employees of State and local governments.

(e) Exemption of certain religious sects

Members of certain religious sects may be exempt from the tax on self-employment income and from social security coverage upon application which would be accompanied by a waiver of benefit rights.

An individual eligible for the exemption must be a member of a recognized religious sect (or a division of a sect) who is an adherent of the established teachings of such sect by reason of which he is conscientiously opposed to acceptance of the benefits of any private or public insurance, making payments in the event of death, disability, old-age, or retirement, or making payments toward the cost of or providing services for, medical care (including the benefits of any insurance system established by the Social Security Act).

The Secretary of Health, Education, and Welfare must find that such sect has such teachings and has been in existence at all times since December 31, 1950, and that it is the practice for members of such sect to make provision for their dependent members which, in the Secretary's judgment, is reasonable in view of their general level of living. The exemption for previous years (taxable years ending prior to December 31, 1965) must be filed by April 15, 1966.

The exemption would be effective as early as taxable years beginning after December 31, 1950.

3. MISCELLANEOUS

(a) Filing of proof

H.R. 6675 extends indefinitely the period of filing of proof of support for dependent husbands, widowers and parent's benefits, and for filing application for lump-sum death payments where good cause exists for failure to file within the initial 2-year period.

(b) Automatic recomputation of benefits

The benefits of people on the rolls would be recomputed automatically each year to take account of any covered earnings that the worker might have had in the previous year and that would increase his benefit amount. Under existing law there are various requirements that must be met in order to have benefits recomputed, including filing of an application and earnings of over \$1,200 a year after entitlement.

(c) Military wage credits

Your committee's bill revises the present provision authorizing reimbursement of the trust funds out of general revenue for gratuitous social security wage credits for servicemen so that such payments will be spread over the next 50 years.

4. FINANCING OF OASDI AMENDMENTS

The benefit provisions of H.R. 6675 are financed by (1) an increase in the earnings base from \$4,800 to \$5,600 (effective January 1, 1966), and \$6,600 (effective 1971), and (2) a revised tax rate schedule.

The tax rate schedule under existing law and the revised schedule provided by the bill for the OASDI program follow :

[In percent]

Years	Employer-employee rate (each)		Self-employed rate	
	Present law	Bill	Present law	Bill
1965.....	3.625	3.625	5.4	5.4
1966.....	4.125	4.0	6.2	6.0
1967.....	4.125	4.0	6.2	6.0
1968.....	4.625	4.0	6.9	6.0
1969-72.....	4.625	4.4	6.9	6.6
1973 and after.....	4.625	4.8	6.9	7.0

5. AMOUNT OF ADDITIONAL BENEFITS IN THE FULL YEAR 1966

7 percent benefit increase (\$4 minimum in primary benefit).....	\$1,430,000,000.
Child's benefit to age 22 if in school.....	\$195,000,000.
Reduced age for widows.....	\$165,000,000 (no long-range charge to system because of actuarial reduction).
Reduction in eligibility requirement for certain persons aged 72 or over.....	\$140,000,000.
Liberalization of disability definition.....	\$105,000,000.
Liberalization of retirement test.....	\$65,000,000.

D. PUBLIC ASSISTANCE AMENDMENTS

1. INCREASED ASSISTANCE PAYMENTS

The Federal share of payments under all State public assistance programs is increased a little more than an average of \$2.50 a month for the needy aged, blind, and disabled and an average of about \$1.25 for needy children, effective January 1, 1966. This is brought about by revising the matching formula for the needy aged, blind, and disabled (and for the adult categories in title XVI) to provide a Federal share of \$31 out of the first \$37 (now twenty-nine thirty-fifths (29/35) of the first \$35) up to a maximum of \$75 (now \$70) per month per individual on an average basis. The matching formula is revised for aid to families with dependent children so as to provide a Federal share of five-sixths (5/6) of the first \$18 (now fourteen-seventeenths (14/17) of the first \$17) up to a maximum of \$32 (now \$30). A provision is included so that States will not receive additional Federal funds except to the extent they pass them on to individual recipients. Effective January 1, 1966. Cost About \$150 million a year.

2. TUBERCULAR AND MENTAL PATIENTS

H.R. 6675 removes the exclusion from Federal matching in old-age assistance and medical assistance for the aged programs (and for combined program, title XVI) as to aged individuals who are patients in institutions for tuberculosis or mental diseases or who have been

diagnosed as having tuberculosis or psychosis and, as a result, are patients in a medical institution. The bill requires as condition of Federal participation in such payments to, or for, patients in mental hospitals certain agreements and arrangements to assure that better care results from the additional Federal money. The States will receive additional Federal funds under this provision only to the extent they increase their expenditures for mental health purposes under public health and public welfare programs. The bill also removes restrictions as to Federal matching for needy blind and disabled who are tubercular or psychotic and are in general medical institutions.

Effective January 1, 1966. Cost: About \$75 million a year.

3. PROTECTIVE PAYMENTS TO THIRD PERSONS

A provision for protective payments to third persons on behalf of old-age assistance recipients (and recipients on combined program, title XVI program) unable to manage their money because of physical or mental incapacity is added by H.R. 6675. Effective January 1, 1966.

4. EARNINGS EXEMPTION UNDER OLD-AGE ASSISTANCE

Your committee's bill increases earnings exemption under old-age assistance program (and aged in combined program) so that a State may, at its option, exempt the first \$20 (now \$10) and one-half of the next \$60 (now \$40) of a recipient's monthly earnings. Effective January 1, 1966. Cost: About \$1 million first year.

5. DEFINITION OF MEDICAL ASSISTANCE FOR AGED

H.R. 6675 modifies the definition of medical assistance for the aged so as to allow Federal sharing as to old-age assistance recipients for the month they are admitted to or discharged from a medical institution. Effective July 1, 1965. Cost: About \$2 million.

6. EXEMPTION OF RETROACTIVE OASDI BENEFIT INCREASE

The bill adds a provision which would allow the States to disregard so much of the OASDI benefit increase (including the children in school after 18 modification) as is attributable to its retroactive effective date.

7. ECONOMIC OPPORTUNITY ACT EARNINGS EXEMPTION

H.R. 6675 also provides a grace period for action by States that have not had regular legislative sessions, whose public assistance statutes now prevent them from disregarding earnings of recipients received under the Economic Opportunity Act.

8. JUDICIAL REVIEW OF STATE PLAN DENIALS

The bill provides for judicial review of the denial of approval by the Secretary of Health, Education, and Welfare of State public assistance plans and of his action under such programs or noncompliance with State plan conditions in the Federal law.

III. GENERAL DISCUSSION OF THE BILL

A. PROVISIONS RELATED TO HEALTH CARE

Today, few older people are free of the fear that costly illness will exhaust their savings. In many instances the one or more episodes of hospitalization which virtually all aged people will experience can quickly dissipate whatever savings they have been able to accumulate for their later years. The frequent medical attention required by older people suffering from chronic illness can also be a serious drain on their financial resources.

A large and growing proportion of the elderly applying for public assistance have had to do so only because they cannot afford needed health care. Frequently the assistance for which they must apply is very limited in scope and inadequate to meet their needs.

Your committee has been concerned about this problem for a number of years. As may be recalled, in 1960 in the 86th Congress after very careful and exhaustive review of the situation and many proposed solutions, the Committee on Ways and Means concluded that further Federal legislation was necessary. The result was the formulation and enactment of the medical assistance for the aged program, more popularly referred to as the "Kerr-Mills" program. At that time it was the view of your committee that such a program should be undertaken to determine whether it would or could adequately meet the national need. It has now been 5 years since enactment of the 1960 Social Security Amendments and there has been opportunity to evaluate the implementation of the medical assistance for the aged program and to formulate a judgment as to the extent to which this national problem is being met. The Committee on Ways and Means has conducted public hearings in the past two Congresses on this subject, the more recent of which was just last year. Although your committee believes that the Kerr-Mills legislation as a whole has been very beneficial to the needy aged in our country, it has now concluded that the overall national problem of adequate medical care for the aged has not been met to the extent desired under existing legislation because of the failure of some States to implement to the extent anticipated and thus the existing program is inadequate to solve the problem. Your committee, therefore, has concluded that a more comprehensive Federal program as to both persons who can qualify and protection afforded is required.

Therefore, a threefold approach to meet this national problem has been developed. First, since your committee believes that Government action should not be limited to measures that assist the aged only after they have become needy, your committee recommends more adequate and feasible health insurance protection under two separate but complementary programs which would contribute toward making economic security in old age more realistic, a more nearly attainable goal for most Americans. In addition, your committee recommends,

as will be discussed later in this report, a strengthening of the medical assistance provisions of the Social Security Act so that adequate medical aid may be provided for needy people.

The first of the two insurance programs consists of protection against the costs of hospital and related care. This hospital insurance plan would be financed through a new special tax separate from existing social security taxes and the contributions collected would be kept entirely separate from the funds of the existing program in a new Federal hospital insurance trust fund. The proposed hospital insurance would be financed through the new tax contributions during the individual's working lifetime with benefits available at age 65.

In past amendments to the Social Security Act, when new programs have been developed or when significant changes have been made to meet a national need, the Congress has followed the practice of extending the new or enhanced benefits not only to those who will become eligible for them in future years but also to the individuals then currently on the rolls. This has been done, of course, with the knowledge that the current beneficiaries on the rolls have not made contributions specifically for increased benefits or the new benefits then being provided. For example, every cash benefit increase which has been provided has been made equally available to the currently retired as well as to those who would retire in the future. A further example is the extension of the disability insurance benefit provisions in 1956 to both the then currently disabled individuals (who met the requirements) as well as to those who would become disabled in the future (and who would meet the eligibility requirements). This, of course, does mean that the already-retired group, which has made no contributions for the hospital insurance part of the program, represents in this sense an "unfunded" liability which has to be met out of future contributions. However, the practice has always been to cover the present beneficiaries and basic to it is the recognition that the problem which such new legislation is designed to meet exists equally with regard to them as with regard to those who will become eligible in the future. It may be noted that the same practices are often followed under private pension plans—namely, to extend benefit liberalizations to existing pensioners on the rolls when doing so for future pensioners.

The second of the two insurance programs is a voluntary supplementary health insurance plan that would cover a substantial part of the cost of physicians' services and a number of other health items and services not covered under the hospital insurance program. At the beginning the voluntary supplementary plan would be financed through monthly premiums of \$3, and through equal, matching contributions from Federal Government general revenues. The combined coverage of the two insurance plans would result in protection for the elderly of a quality that only a few older people can now afford. Most elderly people could be expected to have the protection of both of these insurance programs.

The provision of insurance against the covered costs would encourage participating institutions, agencies, and individuals to make the best of modern medicine more readily available to the aged.

The bill specifically prohibits the Federal Government from exercising supervision or control over the practice of medicine, the manner in which medical services are provided, and the administration or

operation of medical facilities. Further, the bill specifically provides that a beneficiary may obtain services from any participating institution, agency, or person who undertakes to provide him with the services. The responsibility for, and the control of, the care of the beneficiaries rests with the hospitals, extended care facilities, the beneficiaries' physicians, etc.

There will be no coverage of, or payment for, physicians' services under the hospital insurance program, which is financed through the separate payroll tax. Coverage of physicians' services is limited to the voluntary supplementary program which is financed by premiums of beneficiaries and from general funds of the Treasury.

In establishing the complementary plans for medical care for the aged in this bill, no special recognition is being given to the lower rate of hospital utilization which might be experienced by aged persons under comprehensive health care plans. However, it is not the intention of your committee by this action to adversely affect those organizations which provide and operate comprehensive health care services. On the other hand, it is the hope of your committee that the development of comprehensive health care plans be encouraged.

1. BASIC PLAN—HOSPITAL INSURANCE, ETC.

(a) *Eligibility for protection under the basic plan*

The proposed basic hospital insurance would be provided (on the basis of a new section in title II of the act) for people aged 65 and over who are entitled to monthly social security benefits or to annuities under the Railroad Retirement Act. In addition, people who are now aged 65 or will reach age 65 within the next few years and who are not insured under the social security or railroad programs would nevertheless be covered under the basic plan. In July 1966, when the program would become effective, about 17 million people aged 65 and over who are eligible for social security or railroad retirement benefits, and about 2 million aged who would be covered under a special transitional provision, would have the proposed basic hospital insurance.

Included under the special provision would be all uninsured people who have reached 65 before 1968. As to persons reaching 65 after 1967, they would have to have the quarters of coverage that are indicated in the following table:

Quarters of coverage required for OASI cash benefits as compared to hospital insurance

Year attains age 65	Men		Women	
	OASI	Hospital insurance	OASI	Hospital insurance
1967 or before	6-16	0	6-13	0
1968	17	6	14	6
1969	18	9	15	9
1970	19	12	16	12
1971	20	15	17	15
1972	21	18	18	(1)
1963	22	21		
1974	23	(1)		

¹ Same as OASI.

As indicated in the table, by 1974 the quarter coverage required for cash benefits and hospitalization insurance benefits will be the same and the "transitional" provision will phase out.

Together, these two groups comprise virtually the entire aged population. The persons not protected would be Federal employees who retired after July 1, 1960, and have had the opportunity to come under the liberal provisions of the Federal Employees Health Benefits Act of 1959. Others excluded would be aliens who have not been residents of the United States for 10 years and certain subversives.

Currently, 93 percent of the people reaching age 65 are eligible for benefits under social security or railroad retirement and this percentage will rise to close to 100 percent as the program matures. Thus, over the long run virtually all older people will earn entitlement for the proposed hospital insurance.

(b) Benefits

Persons entitled to benefits under the hospital insurance plan would be eligible to have payments made for inpatient hospital care and for important additional benefits covering posthospital extended care, posthospital home health services, and certain outpatient hospital diagnostic studies.

Benefits would be payable for covered hospital and related health services furnished beginning July 1, 1966. Posthospital extended care benefits would be effective January 1, 1967.

(1) Inpatient hospital benefits

The proposed inpatient hospital benefits would, except for a deductible amount, cover the cost of services provided by (or under arrangements with) participating hospitals (including tuberculosis hospitals, but not psychiatric hospitals—the latter would be covered under the voluntary supplementary plan) for up to 60 days in any one "spell of illness." A spell of illness would normally begin with the day a beneficiary enters a hospital and end after the beneficiary has remained out of a hospital and out of an extended care facility for 60 consecutive days.

If a person is in a tuberculosis hospital at the time he becomes entitled to benefits, the days he has already been in the hospital would count toward the 60-day limit on coverage of care in such a hospital during a spell of illness. This provision is in keeping with the intent of the basic plan to cover only the active phase of treatment and not to cover 60 days of care for a person who may have been institutionalized for years previously.

The deductible amount applicable to inpatient hospital services at the beginning of the program would be \$40 per spell of illness. The deductible would be changed thereafter, but not before 1969, to keep pace with increases in hospital costs. Each year, beginning in 1968, the Secretary would determine the amount of the deductible applicable for the succeeding years on the basis of the relationship between the average amount paid per day for inpatient hospital services during the preceding year and the rate for 1966. Increases in the deductible amount would be made in \$5 steps so that changes of a few cents or even of a few dollars would not have to be made immediately following each such change. However, over a period of time these changes would accurately reflect the changes in hospital costs. Small annual

changes would not only be an administrative problem, but they would also increase the problems of keeping beneficiaries informed of the applicable deductible.

Covered services.—The reasonable cost of service ordinarily provided to inpatients by hospitals (other than physician's services, and certain other items), including new services and techniques as they are adopted in the future, would be paid for. Services furnished to inpatients by others under arrangements with a hospital could also be covered if the arrangements call for billing for the services to be through the hospital exclusively. Since the reasonable cost of the services would be covered, hospitals would not be deterred, because of nonpaying or underpaying patients in this aged group, from trying to provide the best of modern care. The following are the major items and services that would be paid for.

Hospital room and board would be paid in full in accommodations containing from two to four beds. Payment would also be made for private accommodations where their use is medically indicated—ordinarily only when the patient's condition requires him to be isolated. Where private accommodations are furnished for the patient's comfort, the payments would cover only the equivalent of the reasonable cost of accommodations containing two to four beds; the patient would pay the extra charges for the private room.

Nursing services ordinarily furnished by hospitals would be paid for, but private duty nursing would not be covered.

Payments would not be made under the hospital insurance plan for the services of physicians, except services provided by interns and residents in training under approved teaching programs. Like other physicians' services, the services of radiologists, anesthesiologists, pathologists, and other physicians employed by the hospital or working through the hospital would be paid for under the voluntary supplementary plan; such services would not be covered under the hospital insurance plan. However, the services of the nonphysicians aiding such persons would be covered under the hospital insurance plan.

Drugs and biologicals furnished to hospital patients for their use while inpatients would be paid for. Payment would be provided for all drugs and biologicals which are listed in the United States Pharmacopoeia or National Formulary or New Drugs or Accepted Dental Remedies (except for any drugs and biologicals unfavorably evaluated therein), or which are approved by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of the hospital furnishing the drugs and biologicals. (These publications have been compiled and are maintained by the professional organizations concerned with the proper use of drugs.) The alternative requirement of approval by a committee of the medical staff of the hospital, is in line with the recommendations of the American Hospital Association, American Medical Association, American Pharmaceutical Association, and the American Society of Hospital Pharmacists. These organizations jointly have recommended that hospitals adopt a formulary system based upon the functioning of a pharmacy and drugs therapeutics committee of the medical staff of the hospital as a means of protecting the hospital's patients against drugs of poor quality. Innovation and the use of new drugs would not be discouraged because such hospital committee could adopt for use any new drugs which it approved.

The exception to the coverage of drugs and biologicals that are listed in the publications New Drugs or Accepted Dental Remedies is intended only to exclude the payment for drugs which have been unfavorably evaluated for all medicinal uses or for the medicinal use to which it is being put.

The intent of the provisions for determining which drugs and biologicals are covered is to permit payment for all drugs and biologicals which medical and medically related organizations have evaluated and selected as being proper for use in the course of good patient care.

There will be a deductible in an amount equal to the cost of the first 3 pints of blood furnished for an individual during a spell of illness. The difference between the cost of the blood to the hospital and the charge to the beneficiary would be deducted from the payments the proposed program would otherwise make to the hospital. Thus the hospital would not make a profit on the blood for which it charges a beneficiary. Your committee included this deduction provision in the interest of the voluntary blood replacement programs, which encourage donations of blood by waiving charges for blood which the patient arranges to replace. The limitation of the deduction to 3 pints of blood was made in view of the problems aged people would have in securing replacement of, or paying for, large quantities of blood.

Supplies and appliances would be paid for under the hospital insurance plan when they are a necessary part of the covered inpatient hospital services a patient receives. For example, the use of a wheelchair, crutches, or prosthetic appliances could be paid for as part of hospital services but payment for hospital services would not cover furnishing these items to the patient for use after his discharge. (However, the cost of using these items after hospitalization might be paid for if needed as part of the posthospital extended care he might receive or it might be provided under a plan for his home health services.) Items supplied at the request of the patient for his convenience, such as television rental in hospitals, would not be paid for under the program.

Conditions of participation.—Your committee's bill lists conditions that hospitals must meet in order to participate in the proposed program. These conditions for participation are included to provide assurance that participating institutions are safe, that they have facilities and organization necessary for the provision of adequate care, and that they exercise their responsibility to discourage improper and unnecessary utilization of their services and facilities. The inclusion of these conditions is designed to support the efforts of the various professional accrediting organizations sponsored by the medical and hospital associations, health insurance plans, and other interested parties to improve the quality of care in hospitals. To allow payments to institutions for services of lower quality than are now generally acceptable might reduce the incentive for establishing high-quality institutions or for maintaining high standards where they now exist.

In order to participate in the program, hospitals would be required to satisfy conditions specified in the bill relating to clinical records, medical staff bylaws, and utilization review. They would also have to meet certain other specified requirements. The bill authorizes the Secretary to prescribe such further requirements as the Secretary finds

necessary in the interest of health and safety. This authority is proposed because it would be inappropriate and unnecessary to include in the legislation all the precautions against fire hazards, contagion, etc., which should be required of institutions to make them safe. The health and safety requirements prescribed by the Secretary (including any requirements requested by a State which are higher than those prescribed for other States), cannot, however, be more strict than the comparable conditions prescribed for accreditation of hospitals by the Joint Commission on Accreditation of Hospitals. Thus, the Secretary could, for example, require participating hospitals to maintain tissue committees which reexamine the condition of the organs removed during surgery and to meet other conditions which the health professions consider necessary to good patient care, but the Secretary could not set the hospital standards above the professionally established level.

Hospitals accredited by the Joint Commission on Accreditation of Hospitals would be conclusively presumed to meet all the conditions for participation, except for the requirement of utilization review (If the Joint Commission adopts a requirement for utilization review, the Secretary could accept accreditation by the Joint Commission as sufficient evidence that a hospital meets all the requirements of the law.) Linking the conditions for participation to the requirements of the Joint Commission provides further assurance that only professionally established conditions would have to be met by providers of health services which seek to participate in the program.

The conditions of participation for tuberculosis hospitals would be similar to those for other hospitals, though differing in some respects due to their different purpose. To provide assurance that the program while paying for active treatment in tuberculosis hospitals would avoid paying for care that is merely custodial, the conditions of participation require that the hospital be accredited by the Joint Commission on Accreditation of Hospitals, that its clinical records be sufficient to permit the Secretary to determine the degree and intensity of treatment furnished to beneficiaries, and that it meet staffing requirements the Secretary finds necessary for carrying out an active treatment program. A distinct part of an institution can be considered a tuberculosis hospital if it meets the conditions even though the institution of which it is a part does not; and if the distinct part meets requirements equivalent to accreditation requirements, it could qualify under the program even though the institution is not accredited.

Your committee recognizes that there will be emergency situations where an individual who is eligible for hospital insurance benefits will go or be taken to a hospital that does not participate in the program. For example, an accident victim might have to be taken immediately to the nearest hospital, either for outpatient diagnosis and treatment or for admission as an inpatient. Your committee's bill would permit the payment of benefits for emergency hospital diagnostic services or inpatient care in such cases until it is no longer necessary from a medical standpoint to care for the patient in a nonparticipating institution. To be paid under the program for its services, the nonparticipating hospital, like participating hospitals, would have to agree not to charge the patient amounts (except the deductibles) in addition to the program's payments for covered services.

Christian Science sanatoriums that are operated or listed and certified by the First Church of Christ, Scientist, in Boston, could participate in the program as "hospitals." The participation of these institutions and the payment for items and services furnished by them would be subject to such conditions, limitations, and requirements as may be provided in regulations. In general, however, your committee intends that payments to Christian Science sanatoriums would cover costs of services ordinarily furnished by these sanatoriums to patients which are comparable to those for which payment could be made to hospitals and intends these sanatorium services to be a substitute for, and not an addition to, medical services that might be furnished to a person if his religious beliefs were not contrary to the use of the usual facilities. Coverages and exclusions applicable to hospital care would also apply in these institutions. For example, the services of a Christian Science nurse would be covered unless her duties are those of a private duty nurse or attendant; similarly, the services of a Christian Science practitioner, who is the Christian Science counterpart of the physician, would not be paid for since physician's services are not paid for under the hospital insurance plan. Payment would only be made for bedfast patients who, except for their religion, would have to have been admitted to a hospital.

(2) Posthospital extended care benefits

Care in an extended care facility will frequently represent the next appropriate step after the intensive care furnished in a hospital and will make unnecessary what might otherwise possibly be the continued occupancy of a high-cost hospital bed which is more appropriately used by acutely ill patients.

The posthospital extended care benefits which would be provided under the hospital insurance plan would cover care in qualified extended care facilities in cases where the patient was hospitalized for 3 or more consecutive days and then transferred to the facility for continued care of the same illness within 14 days of his hospital discharge. A patient who meets the hospital-transfer requirement and who is then discharged from the extended facility to his home could again receive extended care benefits in the same spell of illness without being hospitalized again if he is readmitted to the facility within 14 days after discharge. The hospital-transfer requirement is intended to help limit the payment of the extended care benefits to persons for whom such care may reasonably be presumed to be required in connection with continued treatment following inpatient hospital care and makes less likely unduly long hospital stays. This requirement also helps to assure that before a patient is admitted to an extended care facility his medical condition and needs will have been adequately medically appraised. Immediate transfer from a hospital to a posthospital extended care facility is not required because, in some instances, care in such a facility might be found to be needed, for example, only after a trial at convalescent care at the patient's home proves unsuccessful. Similarly, the period of extended care services may be interrupted briefly and then resumed, if necessary, without hospitalization preceding the readmission to the facility.

Payments could be made for 20 days of care in extended care facilities plus, at the patient's option, 2 additional days of care for each day his hospital stay in a spell of illness is less than 60 days. The payments

would be made for extended care beyond the 20th day of the patient's stay in a facility unless he elects otherwise and his election would determine how many potential hospital days would be converted into extended care coverage and how many conserved for possible future need. However, no more than a total of 100 days of extended care benefits could be paid for during any one spell of illness. (The 20 basic days plus up to an additional 80 days as a result of the 2-for-1 formula.)

The number of days of inpatient hospital care for which payments could be made during a spell of illness would be reduced by 1 day for every 2 days of extended care above 20 for which payment is made.

Covered services.—The program would cover the items and services generally furnished by posthospital extended care facilities. These include room and board in two- to four-bed accommodations, nursing care, physical, occupational and speech therapy, and such drugs as are ordinarily furnished by the facility to its inpatients. In addition, payment could be made for the medical services of interns and residents in training and other diagnostic and therapeutic services furnished inpatients of the extended care facility by a hospital with which it has an agreement for the transfer of patients and exchange of medical records. Payment would also be made for physical, occupational, and speech therapy furnished by a party other than the facility if furnished under arrangements which provide for payment for therapy to be made through the facility. In no case could payment be made for any service, drug or other item which could not be paid for under the hospital insurance program if furnished in a hospital. Neither could payment be made for services not generally provided by posthospital extended care facilities. For example, under this rule the use of an operating room would not be covered in the case of an extended care facility since operating rooms are not generally maintained as part of such facilities.

Conditions for participation.—A posthospital extended care facility could be an institution, such as a skilled nursing home, or a distinct part of an institution, such as a ward or wing of a hospital or a section of a facility another part of which might serve as an old-age home. To assure that there will be no unnecessary barriers to the transfer of patients between hospital and extended care facilities when the attending physician determines the transfer is medically appropriate, a participating facility would be required (except as noted in the next paragraph) have an agreement with a hospital for the transfer of patients and interchange of medical records. The requirement of a transfer arrangement does not mean that a patient would have to be transferred between a hospital and extended care facility which have such an arrangement with each other in order to qualify for extended care benefits. A transfer arrangement with any hospital would qualify the facility so that a patient's posthospital extended care would be paid for if he was admitted from any hospital.

Where an extended care facility has attempted, in good faith, to arrange a transfer agreement with nearby hospitals, but failed, the State agency could waive the requirement for a transfer agreement if the agency finds that the facility's participation is in the public interest and essential to assuring extended care to older people in the particular community.

Extended care facilities would also be required to satisfy a number of conditions necessary for an institutional setting in which high-quality convalescent and rehabilitation care can be furnished. These include conditions relating to the provision of around-the-clock nursing services with at least one registered nurse employed full time, the availability of a physician to handle emergencies, the maintenance of appropriate medical policies governing the facility's skilled nursing care and related services, methods and procedures for handling drugs, and utilization review. In addition to the conditions specified in the bill, the Secretary would be authorized to prescribe such further requirements to safeguard the health and safety of beneficiaries as he may find necessary.

(3) *Posthospital home health care benefits*

Payments would be made for visiting nurse services and related home health services when furnished in accordance with a plan established and periodically reviewed by a physician. The proposed payments would be made only for a patient who is under the care of a physician and confined to his own home (except when he is taken elsewhere to receive services which cannot readily be supplied at home). Since the nature and extent of the care a patient would receive would be planned by a physician, medical supervision of the home health services furnished by paramedical personnel—such as nurses or physical therapists—would be assured.

Up to 100 visits by home health personnel would be paid for during a 1-year period following the patient's discharge from a hospital or extended care facility. To be eligible for home health benefits, the beneficiary would have to have been an inpatient in a hospital for at least 3 days or in an extended care facility and a home health plan for his care would have to be developed by a physician and steps would have to be taken to implement the plan within 14 days after his discharge.

A "visit" would be defined in regulations. It is contemplated, for example, that ordinarily one visit would be charged each time home health personnel furnish a covered service to the patient. For instance, a visit would be charged each time a therapist would go to the patient's home to furnish speech therapy. If a beneficiary had a visit from a speech therapist and a visiting nurse in the same day, two visits would be charged. Similarly, if the patient were to be taken to a hospital to receive outpatient therapy that could not be furnished in his own home—hydrotherapy, for example—and also received speech therapy and other services at the hospital in the course of the same visit, two or more visits might be charged.

Covered services.—The proposed posthospital home health payments would meet the cost of part-time or intermittent nursing services, physical, occupational, and speech therapy, and other related home health services furnished by visiting nurse agencies, hospital-based home health programs and similar agencies. More or less full-time nursing care would not be paid for under the home health benefits provision. Payments could be made for services furnished by other parties under arrangements with such agencies—the services of an independent physical therapist and interns and residents in training of an affiliated hospital, for example.

To the extent permitted in regulations, the part-time or intermittent services of a home health aide would also be covered. The duties of the home health aide which would be covered are comparable to those of a nurse's aide in the hospital who would have had training and experience that is not ordinarily possessed by lay people—for example, training and experience in giving bed baths to ill and bedfast patients. Often, the home health aide's services are essential if the patient is to be cared for outside a hospital or nursing facility. Food service arrangements, such as those of meals-on-wheels programs, or the services of housekeepers would not be paid for under the home health provisions.

While the home health patient would have to be homebound to be eligible for benefits, provision is made for the payment for services furnished at a hospital or extended care facility or rehabilitation center which requires the use of equipment that cannot ordinarily be taken to the patient in his home. In some cases special transportation arrangements may have to be made to bring the homebound patient to the institution providing these special services. The transportation itself would not be paid for. If he is furnished other services at the hospital or facility at the same time, these too could be paid for, even though they are of a kind that could be furnished in the patient's home. But such services would be covered only if they are furnished under arrangements which provide for billing through the home health agency. For example, if it is necessary, because of the size of the equipment involved, to take the patient to a hospital to give him physical therapy and while at the hospital he receives speech therapy, benefits could be paid for both services, but only if the home health agency takes responsibility for arranging and billing for all the services.

Conditions for participation.—The conditions for participation of home health agencies are designed primarily to assure that participating agencies are basically suppliers of health services. The proposal would cover visiting nurse organizations as well as agencies specifically established to provide a wide range of organized home health services. It would also cover home health services provided by a community hospital. In order to participate, the home health agency or organization would, in addition to meeting certain other requirements, either have to be publicly owned or be a nonprofit organization exempt from Federal taxation or it would have to be licensed and satisfy staffing requirements and other standards and conditions prescribed by regulation. It is the understanding of your committee that organizations providing organized home care on a profit basis are presently nonexistent. However, the language of the bill permits covering such agencies if they come into being, are licensed, and meet the high standards which the present nonprofit agencies offering organized care meet.

(4) *Outpatient hospital diagnostic benefits*

Finally, payment could be made for tests and related services—other than those performed by physicians—that are ordinarily furnished by a participating hospital to its outpatients for the purpose of diagnostic study. Payments could also be made for such service furnished by others under arrangements with the hospital that provide for the billing to be through the hospital. Where the services are furnished outside the hospital, they would have to be furnished in facilities

operated by or under the supervision of the hospital or its organized medical staff. (Diagnostic tests performed in a physician's office would, like other physicians' services, generally be covered under the voluntary supplementary plan unless part of a routine physical checkup.)

A deductible amount equal to one-half the deductible amount applicable in the case of inpatient hospital services would be applied against payments for outpatient hospital diagnostic services furnished by the same hospital during a 20-day period. The deductible would be \$20 initially ($\frac{1}{2}$ of \$40). If, within 20 days after receiving outpatient diagnostic services, the individual is hospitalized as an inpatient in the same hospital, the amount he paid for the outpatient diagnostic services (up to the amount of the outpatient deductible) would be credited against the inpatient deductible. Crediting the outpatient deductible in this way is intended to encourage the use of outpatient diagnostic tests rather than creating a situation where a patient would be inclined to insist on going into the hospital for the tests if he saw that he might, in the absence of this provision, have to pay this \$20 deductible plus the \$40 hospital deductible. Through this provision for correlating the deductibles the deductible amount to be paid by a hospitalized beneficiary would be the same whether the diagnostic tests are performed on a hospital inpatient or outpatient basis.

(c) Method of payment

The bill provides that the payment to hospitals and other providers of services shall be equal to the reasonable cost of the services and that the methods to be used and the items to be included in determining the cost shall be developed in regulations of the Secretary in accordance with the provisions of the bill. The regulations may provide for payment of the costs of services on a per diem, per unit, per capita, or other basis, may provide for the use of estimates in different circumstances, may provide for the use of estimates of cost of particular items or services, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the cost.

The appropriate basis of payment for hospital services when payment is made by public or private agencies has been the subject of extended and painstaking consideration for more than a decade. Governing principles have been developed which have attained a large measure of agreement. It is the intent of the bill that in framing regulations full advantage should be taken of the experience of private agencies in order that rates of payment to hospitals may be fair both to the institutions, to the contributors to the hospital insurance trust fund, and to other patients. In framing the regulations the Secretary and his staff will consult with the organizations that have developed these principles as well as with leading associations of providers of services.

Similar principles can without undue difficulty be developed to establish fair bases of payment to extended care facilities and home health services agencies.

The cost of hospital services varies widely from one hospital to another and the variations generally reflect differences in quality and intensity of care. The same thing is true with respect to the cost of the services of other providers. The provision in the bill for

payment of the reasonable cost of services is intended to meet the actual costs, however widely they may vary from one institution to another, except where a particular institution's costs are found to be substantially out of line with those of institutions similar in size, scope of services, utilization, and other relevant factors.

Although payment may be made on various bases the objective, whatever method of computation is used, will be to approximate as closely as practicable the actual cost (both direct and indirect) of services rendered to the beneficiaries of the program so that under any method of determining costs, the costs of services of individuals covered by the program will not be borne by individuals not covered, and the costs of services of individuals not covered will not be borne by the program. The basis for the computation of the cost of beneficiaries may vary by institution. The most usual hospital cost reimbursement procedures now in use by plans that pay for inpatient services are based on the average per diem cost of the patients in the institution to which payment is made, adjusted to reflect the provisions of the plan. Some institutions, however, base their charges to the public on careful cost ascertainment or accounting and change their charges only when there is a change in the cost of the service involved. In these and other appropriate cases reimbursement would be permitted on the basis of the ratio of cost to charges for the services actually received.

In other institutions some of the charges are set according to prevailing rates in the area, or are based on other considerations and not solely on the actual costs of the particular items and services rendered. Except where a close correlation of cost and charges would be shown, other methods would have to be applied to achieve equitable reimbursement.

The concept of reasonable cost and the principles and methods for translating this concept into practice in individual circumstances are of concern to consumers, providers of service, insuring organizations, and State and Federal governmental programs.

In the determination of reasonable costs of services consideration should be given to all necessary and proper expenses incurred in rendering the services, including normal standby costs. Reasonable costs should include appropriate treatment of depreciation on buildings and equipment (taking into account such factors as the effect of Hill-Burton construction grants and practices with respect to funding of depreciation) as well as necessary and proper interest on capital indebtedness.

Many hospitals engage in substantial educational activities, including the training of medical students, internship and residency programs, the training of nurses, and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program.

Identifiable expenses for medical research, on the other hand, over and above the costs closely related to normal patient care, would not be met from the trust fund. Available research funds are generally ample to support important basic medical research.

In some cases, the charges hospital patients pay include a share of the cost of rendering services to free and part-pay patients as well as a share of uncollectible bills. Your committee has given careful consideration to the question of the effect that the proposed program would have on charges to other paying patients. The insurance system will reduce the losses of hospital income from bad debts or for care of free or part-pay aged patients which might otherwise be included in charges to other paying patients by paying the full cost, except for the deductible, for substantially all patients over 65. Under the public assistance programs now existing and even more as they would exist under the provisions of this bill, the Federal Government will make a very substantial contribution toward the medical care of the needy of all ages. Under the bill more of the needy could be aided under the Federal-State assistance programs. Further, the proposed amendments would require under the medical assistance and maternal and child health and crippled children programs of the Social Security Act the payment of the reasonable costs of covered hospital services. This will assist hospitals in reducing the income deficits arising out of providing hospital care to persons unable to pay for care.

These provisions, taken in combination with the hospital insurance system under part A of title XVIII, will appreciably reduce the need of hospitals to charge their paying and prepaying patients more than the cost of their services in order to compensate for care rendered to other patients without charge or at less than cost. The bill will thus make a contribution toward rationalizing the distribution of hospital costs and relieving voluntary insurance and prepayment systems, as well as those patients who pay for services at the time when they are rendered, of some part of the burden they now bear for indigent and charity patients.

In paying reasonable costs it is the policy of the insurance program to so reimburse a hospital or other provider that an accounting may be made at the end of each cost period for costs actually incurred.

(d) Financing

The hospital insurance program would be financed through a separate payroll tax that would be paid by employees, employers, and the self-employed. The proceeds of this tax would be earmarked in a newly established hospital insurance trust fund, which means that these funds will be kept completely separate from the taxes which support the present social security program. The earnings base of the new tax would be the same base as that for the social security tax so that the recordkeeping tasks of employers and the Government would be left largely unaffected by the establishment of a separate contribution for hospital insurance. To assure that the hospital insurance contributions are clearly identified as such to contributors, the bill requires that the withholding forms, W-2's, show what proportion of the worker's total tax payment was withheld to finance the cost of the proposed hospital insurance. Hospital insurance benefits and administrative expenses would be paid only from the hospital insurance trust fund.

The complete separation of hospital insurance financing and benefit payments is intended to assure that the hospital insurance program will in no way impinge upon the financial soundness of the old-age, survivors, and disability insurance trust funds. A separate annual re-

port will be required on the operation of the hospital insurance program. Furthermore, identifying the contribution as a hospital insurance contribution will tend to increase the contributor's sense of financial responsibility for the benefits provided.

Under the proposed schedule of contribution rates, the fund would, be sufficient to cover all the costs of the hospital insurance benefits (and administration) for persons entitled to social security or railroad retirement benefits. The schedule of contribution rates is the same for employers, employees, and self-employed persons and is as follows:

	Percent		Percent
1966.....	0.35	1976-79.....	0.60
1967-72.....	.50	1980-86.....	.70
1973-75.....	.55	1987 and after.....	.80

As will be explained in greater detail later in this report, the schedule of contribution rates is based on conservative estimates of cost. The cost estimates also use the assumption that, while earnings will continue to rise in the future as they have in the past, the annual limitation on taxable earnings will not be increased beyond the last increase provided for in your committee's bill (\$6,600 in 1971 and thereafter). If the earnings base is increased after 1971, the tax rates in the contribution schedule could be revised downward. In fact, if the earnings base does rise to keep up to date with the general earnings level, the steps in the contribution schedule beyond the rate of 0.55 percent would not be needed.

The cost of providing hospital and related posthospital insurance benefits to people who are not social security or railroad retirement beneficiaries would be met from general revenues.

2. VOLUNTARY SUPPLEMENTARY PLAN

(a) *Eligibility and enrollment under the voluntary supplementary plan*

The proposed supplementary health insurance would be available to all people age 65 and over (whether or not they are social security or railroad retirement beneficiaries) who are residents of the United States and either citizens or aliens admitted for permanent residence. Enrollment in the supplementary plan would be on a voluntary basis.

In general, an eligible person could enroll during the period beginning with the third month preceding the month in which he attains age 65 and ending 7 months later. The supplementary insurance would be effective with the first day of the third month following the month in which he enrolls (but not earlier than July 1, 1966). (If an eligible person enrolled in the first month of the 7-month period, his coverage would be effective with the month in which he reaches age 65.)

A special enrollment period would be available at the beginning of the program for people who have already reached 65 by December 31, 1965. This enrollment period would begin with the first day of the second month after the month in which the bill is enacted and end on March 31, 1966. Coverage under the supplementary insurance for people who enroll during this period would begin with July 1, 1966. Individuals who are eligible to enroll during this initial general enrollment period but fail to do so could enroll at any time before October 1, 1966, if the Secretary determines that there was good cause for the individual's failure to enroll. However, if an individual en-

rolls under the latter provision, his coverage could not begin until the sixth month after he enrolls. Monthly premiums would be collected for each month during which an individual was covered under the program.

There would be a general enrollment period between October 1 and December 31 of 1967 and during the comparable period in every odd-numbered year thereafter. A person who enrolls in a general enrollment period would get protection effective with the July 1 following the general enrollment period.

No one could enroll for the first time more than 3 years after the close of the first enrollment period open to him and no one could reenroll unless he does so in a general enrollment period which begins within 3 years of the date his previous enrollment was terminated. A person could reenroll only once.

The limitations on enrollment and reenrollment such as those recommended are made in order to reduce the possibility of people enrolling in the program when their health deteriorates, thus increasing costs by covering people during periods of ill health who chose not to be covered during periods of good health.

The Secretary also is authorized to enter into an agreement with any State which, before July 1, 1967, elects to have certain of its money payment recipients covered by the supplementary plan. States would be permitted to decide whether to request enrollment of the money payment recipients of OAA or such recipients who are 65 years of age and older who are receiving money payments under the combined program, title XVI, or to decide to request coverage for all the aged among the money payment recipients under titles I, IV, X, XIV, and XVI. Excluded from coverage under this arrangement are those persons who are entitled to receive a benefit under the old-age, survivors, and disability insurance system, or the Railroad Retirement Act. The State would pay, in behalf of each individual who is to be enrolled, the premium charge that is determined by the provisions of the bill. Those recipients of public assistance money payments who become 65 years of age on or after July 1, 1967, and who are eligible to enroll individually may have their monthly premium charges paid by the public assistance agency with Federal financial participation. However, your committee believes that it is not practicable at this time to authorize States to cover recipients of medical assistance for the aged through vendor payments under an agreement or to make premium payments in their behalf.

The bill provides that under certain circumstances, the State public welfare agency may act as the carrier in the State for the administration of those provisions with respect to individuals who are receiving money payments under public assistance programs, whether such individuals are covered by the agreement or not.

The agreement may also include provisions for transfer of public assistance funds to another carrier, if the State is not serving as a carrier, so that the insurance benefits and deductibles, coinsurance, and other items met by the State under its public assistance plans can be merged for purposes of paying providers of medical care.

(b) Benefits under the voluntary supplementary plan

The voluntary supplementary plan would provide protection that builds upon the protection provided by the hospital insurance plan. It

would cover physicians' services, additional home health visits, care in psychiatric hospitals and a variety of medical and other services not covered under the hospital insurance plan. The beneficiary would pay the first \$50 of expenses he incurs each year for services of the type covered under the plan. Above this deductible amount, the plan would pay 80 percent of the reasonable costs in the case of services provided by an institution or home health agency and 80 percent of reasonable charges for other covered services, with 20 percent being paid by the beneficiary.

Benefits under the supplementary plan would be provided for:

- (1) Physicians' services, including surgery, consultation, and home, office, and institutional calls.
- (2) Medical and other health services. These would include:
 - (a) Diagnostic X-ray and laboratory tests and other diagnostic tests;
 - (b) X-ray, radium, and radioactive isotope therapy;
 - (c) Surgical dressings, splints, casts, and other devices for reduction of fractures and dislocations;
 - (d) Rental of durable medical equipment, such as iron lungs, oxygen tents, hospital beds, and wheelchairs;
 - (e) Prosthetic devices (other than dental) which replace all or part of an internal body organ;
 - (f) Ambulance services with limitations;
 - (g) Braces and artificial legs, arms, and eyes.
- (3) Inpatient psychiatric hospital services for up to 60 days during a spell of illness (subject to a lifetime maximum of 180 days).
- (4) Home health services for up to 100 visits during a calendar year (without a requirement of prior hospitalization).

The \$50 deductible would be applied on a calendar year basis, except that expenses the individual incurred in the last 3 months of the preceding calendar year would be counted as satisfying the deductible if they had been counted toward the deductible in that year. This special carryover provision would avoid requiring persons with substantial costs at the end of 1 year to meet the deductible perhaps early in the next year as though they had had no prior bills.

There would be a special limitation on benefits for expenses in connection with treatment of mental, psychoneurotic, and personality disorders of a person who is not a hospital inpatient. During any year, a maximum of \$312.50 or 62½ percent of the expenses involved, whichever is smaller, would be considered incurred expenses—that is, expenses used in calculating benefit payments. The effect of this provision is to limit payment under the plan to a maximum of \$250 (80 percent of \$312.50) or half of the incurred expense (80 percent of 62½ percent of the expense), whichever is less.

Expenses for the first 3 pints of blood furnished a person in a psychiatric hospital during a spell of illness would not be considered incurred expenses (for which the program could make payment) unless the individual had already received 3 pints of blood which was not paid for under the hospital insurance plan because of the similar exclusion under that plan.

Ambulance services would be covered only where other methods of transportation are not feasible due to the individual's condition, and only to the extent provided in regulations. It is the intention of your

committee that transportation by ambulance be covered only if (a) normal transportation would endanger the health of the patient and (b) the individual is transported to the nearest hospital with appropriate facilities or to one in the same locality, and under similar restrictions, from one hospital to another, to the patient's home or to an extended care facility.

If a person is in a psychiatric hospital at the time he becomes entitled to benefits, the days he has already been in the hospital would count toward the 60-day limit on coverage of care in such a hospital during a spell of illness, but they would not count toward the 180-day lifetime limit. This provision is in keeping with the intent of the plan to cover only the active phase of treatment of mental illness and not to cover 60 days of care for a person who may have been institutionalized for years previously. The services covered under the supplementary plan as inpatient psychiatric hospital services would generally be the same as the services that are covered as inpatient hospital services under the hospital insurance plan.

The conditions of participation for psychiatric hospitals would be similar to those for other hospitals, though differing in some respects. To provide assurance that the supplementary plan, while paying for active treatment in psychiatric hospitals, would avoid paying for care that is merely custodial, the conditions of participation require that the hospital be accredited by the Joint Commission on Accreditation of Hospitals, that its clinical records be sufficient to permit the Secretary to determine the degree and intensity of treatment furnished to beneficiaries, and that it meet staffing requirements the Secretary finds necessary for carrying out an active treatment program. A distinct part of an institution can be considered a psychiatric hospital if it meets the conditions even though the institution of which it is a part does not; and if the distinct part meets requirements equivalent to accreditation requirements, it could qualify under the program even though the institution is not accredited. For inpatient psychiatric hospital services, the certification required of physicians would be appropriate to the condition being treated and somewhat different from that for inpatient hospital services under the hospital insurance program.

Covered home health services and the conditions of participation for home health agencies would be the same as under the hospital insurance plan. There would, however, be no requirement, as there is in the hospital insurance plan, that benefits be paid only when the patient was previously hospitalized.

(c) Method of payment under the voluntary supplementary plan

After the individual has incurred the \$50 deductible amount, the plan would pay 80 percent of the reasonable costs of or the reasonable charges for the covered services. In the case of services (other than physicians' services) furnished by, or under arrangements made by, hospitals, extended care facilities, and home health agencies, payment would be 80 percent of reasonable costs and would be made to the provider of services by the carrier administering the benefits under the supplementary plan. In all other cases, payment would be 80 percent of reasonable charges and would be made by the carrier to the beneficiary unless the beneficiary assigned the benefits to the person or organization which furnished the covered services.

Reasonable cost, as defined for purposes of reimbursement under the supplementary plan, would be the same as under the hospital insurance plan. The carriers administering the benefits under the supplementary plan would, under the terms of their contracts with the Secretary, have to take such action as may be necessary to assure that where payment is on a cost basis, the cost is reasonable cost. In general, under the supplementary plan a provider of services (a covered hospital, extended care facility, or home health agency) could charge a beneficiary the \$50 deductible and 20 percent of the reasonable charges (in excess of the \$50 deductible) for the covered services.

Where payment by the program is on the basis of charges (for physicians' services and medical and other health services not furnished by providers of services), the carriers would take action to assure that the charge on which the reimbursement is based is reasonable and is not higher than the charge used for reimbursement on behalf of the carriers' own policyholders or subscribers for comparable services and under comparable circumstances. In addition, where payment is on the basis of an assignment, the reasonable charge would have to be accepted as the full payment. In determining reasonable charges, the carriers would consider the customary charges for similar services generally made by the physician or other person or organization furnishing the covered services, and also the prevailing charges in the locality for similar services.

(d) Financing

Your committee's bill establishes a premium of \$3 a month initially for individuals who enroll under the supplementary plan. Since the minimum increase in cash social security benefits provided under the bill for retired workers 65 and over would be \$4 a month (\$6 a month for man and wife who are both 65 and are receiving benefits based on the same earnings record), the minimum benefit increase would fully cover the amount of monthly premiums for the supplementary plan. Persons enrolling who are entitled to monthly social security or railroad retirement benefits would have the premiums deducted from their monthly benefits. (Of course, enrollment in the plan is voluntary.) Deducting the premium from monthly benefits would help keep collection costs to a minimum. The method of collecting premiums for those who are not entitled to monthly benefits would be prescribed by the Secretary. People who are entitled to monthly benefits but who, because they have not retired, may not actually receive them or those who may receive only a part of them could estimate the amount by which premiums will exceed the amount of their benefits and could pay in advance the required additional amount to the Secretary. If advance payment is not made in these cases, the annual calculation of adjustment in benefits needed where a beneficiary has worked in the prior year would take into account the premiums owed and paid in connection with the supplementary plan.

Provision is made for the Secretary to adjust the premium amounts supporting the program if medical or other costs rise, but there would be no increase in premiums before 1968, and increases would be made not more often than every 2 years after 1968. To take into account the higher cost of insuring an older individual, premiums payable by a person who enrolled later than the first period when enrollment was open to him or who reenrolled after his enrollment was terminated

would be increased by 10 percent for each full year he could have been but was not enrolled.

There would be a contribution from Federal general revenues equal to the aggregate premiums payable by enrollees. In addition, funds could be appropriated in fiscal year 1966 and remain available through the next fiscal year as repayable advances (without interest) to the trust fund in order to provide an operating fund at the beginning of the program and to provide a contingency reserve. The maximum that could be appropriated for this purpose would be \$18 per person eligible to enroll at the beginning of the supplementary program, July 1, 1966.

A new separate trust fund would be established—the Federal Supplementary Health Insurance Benefits Trust Fund. All premiums and Government contributions for the supplementary program would be paid into the fund and all benefits and administrative expenses would be paid from the fund.

3. GENERAL PROVISIONS RELATING TO THE BASIC AND VOLUNTARY SUPPLEMENTARY PLANS

(a) Conditions and limitations on payment for services

(1) Physicians' role

Your committee's bill provides that the physician is to be the key figure in determining utilization of health services—and provides that it is a physician who is to decide upon admission to a hospital, order tests, drugs and treatments, and determine the length of stay. For this reason the bill would require that payment could be made only if a physician certifies to the medical necessity of the services furnished. If services are furnished over a period of time to be specified in regulations, recertification by the physician would be necessary. Delayed physician certifications and recertifications, accompanied by medical and other evidence, to the extent provided by regulations, could be accepted in lieu of timely certifications and recertifications when, for example, the patient was unaware of his eligibility for the benefits when he was treated.

In the case of inpatient hospital services for which payment would be made, the bill would require that a physician certify that the services were required for an individual's medical treatment, or that inpatient diagnostic study was medically required and that the services were necessary for such purpose. The first physician recertification in each case of inpatient hospital services furnished over a period of time would be required no later than the 20th day of the period. In the case of outpatient hospital diagnostic services, a physician would have to certify that the services were required for diagnostic study.

In the case of posthospital extended care a physician would have to certify that the care was required because the individual needed skilled nursing care on a continuing basis for a condition with respect to which he was receiving inpatient hospital services prior to transfer to the extended care facility or for a condition which arose after such transfer and while the individual was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services.

In the case of home health services, a physician would have to certify that the services were required because the individual was confined

to his home. He would also have to certify that the individual needed (except for receipt of special treatment at a medical institution) skilled nursing care on an intermittent basis or physical or speech therapy. In the case of home health services, the intermittent nursing care or the physical or speech therapy would have to be for treatment of a condition for which the individual had received inpatient hospital services or posthospital extended care.

Your committee recognizes that there often is a significant difference between treatment provided in mental and tuberculosis hospitals and the treatment provided in other hospitals. Often the care in such institutions is purely custodial and it is the intent of the bill to cover only active care intended to cure patients in such hospitals and not to cover custodial care. Therefore, the bill would require that a physician make specific certifications before payment could be made for inpatient hospital services furnished in either a psychiatric hospital or a tuberculosis hospital. In the case of inpatient hospital services furnished in a psychiatric hospital for the psychiatric treatment of an individual, a physician would have to certify that the psychiatric services could reasonably be expected to improve the condition for which the treatment was necessary or that inpatient diagnostic study was medically required and inpatient psychiatric hospital services were necessary for such purposes. In the case of inpatient tuberculosis hospital services a physician would have to certify that the services were required to be given on an inpatient basis for the treatment of an individual for tuberculosis and that the treatment could reasonably be expected to either improve the condition for which the treatment was necessary or render the condition noncommunicable.

(2) Utilization review

The provisions of your committee's bill with respect to mechanisms for the review of utilization of services follow the kind of recommendations for utilization review that have been made by private study groups, State and national medical societies, and State agencies.

Hospitals and extended care facilities participating in the program would be required to have in effect a utilization review plan providing for a review of admissions to the institution, length of stays, and the medical necessity for services provided with the objective of promoting the efficient use of services and facilities. The review would ordinarily be carried out by a staff committee of the institution, which would have to include two or more physicians but which could also include other professional personnel such as registered nurses and medical social workers. Alternatively, the review could be conducted by a similar group outside the institution—preferably one established by the local medical society and some or all of the hospitals and extended care facilities in the locality. In some circumstances the review committee would have to be one outside the institution—for example, where the small size of the institution or, in the case of an extended care facility, the lack of an organized medical staff makes it impracticable for the institution to have a properly functioning staff committee. As mentioned previously, if and when the Joint Commission on the Accreditation of Hospitals adopts a utilization review requirement for accreditation, the Secretary could accept accreditation by the Joint Commission as sufficient evidence that a hospital meets the requirements of the law.

Under a utilization review plan, timely review would have to be made of each case in which a beneficiary stays in the institution for an extended period. Regulations would provide the institution some leeway in determining when the review would have to be carried out, and the point at which a review would be most appropriate might vary with the diagnosis and treatment involved. Where timely reviews are not being made, the Secretary could, in lieu of terminating the agreement under which the institution participates in the program, make a decision that with respect to that institution the program would make payment only for the first 20 days of a beneficiary's stay in the case of a hospital, or only for days up to a specified number (to be specified in regulations) in the case of an extended care facility.

The attending physician would have to be offered an opportunity for consultation before there could be a finding that a beneficiary's further stay in the institution is not medically necessary, by the physician members of the review group; and the individual, the institution and the attending physician would have to be promptly notified of any such finding. Where such a finding has been made, the program could not make payment for services furnished the patient after the third day following the day on which the institution received notice of the finding.

Under your committee's bill, various organizations participating in the administration of the program could have a role in facilitating utilization review. State agencies could provide consultative services to assist in the establishment of utilization review procedures and in evaluating their effectiveness. Under the hospital insurance plan, public or private organizations nominated by providers must assist in the application of safeguards against unnecessary utilization. Carriers administering benefits under the voluntary supplementary plan would determine compliance with the utilization review requirement; assist in the establishment of review groups outside hospitals; assist hospitals, extended care facilities and others who furnish covered services to develop procedures relating to utilization practices; and make studies of such procedures and methods for their improvement.

(b) Exclusions from coverage

Your committee's bill would exclude certain health items and services from coverage under both the hospital insurance and the voluntary supplementary health insurance programs in addition to any excluded through the operation of other provisions of the bill. For example, the bill would bar payment for health items or services that are not reasonable and necessary for the treatment of illness or injury or to improve the functioning of a malformed body member. Thus, payment could be made for the rental of a special hospital bed to be used by a patient in his home only if it was a reasonable and necessary part of a sick person's treatment. Similarly, such potential personal comfort items and services as massages and heat lamp treatments would only be covered where they contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member. Expenses for custodial care would also be excluded.

The proposed insurance programs would not pay for any item or service furnished an individual if neither the individual nor any other person (such as a prepayment plan) has a legal obligation to pay

for or provide the services. (Under the provision, the third-party liability statute 42 U.S.C. 2651-2653 would not apply.) Free chest X-rays provided by health organizations, for example, would not be covered. Where health expenses are charged the patient by a member of the patient's household or by an immediate relative, no payment would be made. However, a person of little means would not be barred from payment under the insurance programs because he met the test of medical indigency and was otherwise eligible to receive medical assistance under a public assistance program. Furthermore, if a person received his care on some prearranged basis toward which he prepaid, the program provided for under the title would nevertheless pay its benefits in full. Your committee expects that the patient's prepayment arrangement would be adjusted appropriately in consideration of the fact that the program met part of the patient's health costs. Except in such cases as the Secretary may specify, no payment would be made for items and services which are paid for directly or indirectly by a governmental entity.

Payments would only be made for items and services provided in the United States, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa. Payment would not be made for items and services required as a result of war or an act of war which occurs after the effective date of the individual's coverage under the proposed insurance.

Payments would not be made for routine physical examinations or for eyeglasses, hearing aids or the fitting expenses or other costs incurred in connection with their purchase. Thus, payment would be made under the supplementary plan for the physician's services connected with the diagnosis of a specific complaint and the treatment of the ailment, but a routine annual or semiannual checkup would not be covered. Similarly, the diagnosis and treatment by an ophthalmologist of, say, cataracts would be covered but the expenses of an eye examination to determine the need for eyeglasses and charges for prescribing and fitting eyeglasses or contact lenses would not be covered. Neither would payment be made for orthopedic shoes or other supportive devices for the feet.

Expenses for cosmetic surgery would not be covered except where incurred in connection with the prompt repair of an accidental injury or to improve the functioning of a malformed body member. For example, cosmetic surgery could be paid for when furnished in connection with the treatment of a severely burned person.

Payment would not be made for health items and services to the extent that payments have been made, or can reasonably be expected to be made, for them under a workmen's compensation law. The Secretary would prescribe regulations to govern the making of payments where a beneficiary's status under workmen's compensation has not been ascertained. Payment would be made under the insurance plans on the condition that repayment would be made if information is received that a workmen's compensation payment for the health care has been made.

(c) Administration of health insurance provisions

Overall responsibility for administration of the hospital insurance and voluntary supplementary health insurance programs would rest with the Secretary of Health, Education, and Welfare, but State

agencies and private organizations operating under agreements with the Secretary and private carriers or public organizations operating under contracts with the Secretary would have a major administrative role. In addition to using such organizations under the conditions described below, the Secretary would be authorized to purchase or contract separately for services such as auditing or cost analysis.

(1) Advisory and review groups

Your committee's bill provides for the establishment of a Health Insurance Benefits Advisory Council to advise the Secretary on general administrative policy matters and on the formulation of regulations in connection with the hospital insurance program and supplementary health insurance program, including regulations relating to conditions of participation for providers. The Advisory Council, appointed by the Secretary, would consist of a chairman and 15 members including persons outstanding in hospital, medical, and other health activities and at least one representative of the public. The members could not include regular Federal Government employees.

The bill also provides for the establishment of a National Medical Review Committee to study the utilization of hospital and other medical care and services with a view to recommending changes in the way covered care and services are used and in the administration of the basic and supplemental plans.

The committee is required to make an annual report of its recommendations to the Secretary, and he is required to transmit the report to the Congress.

The committee is to be composed of nine persons, one of whom the Secretary would designate as chairman. The members are to be selected from people who are representative of organizations and associations of professional people in the field of medicine and other people who are outstanding in the field of medicine or related fields and a majority of the committee are to be physicians and at least one member will represent the general public. Regular Federal Government employees could not be members of the committee.

(2) Conditions of participation

In formulating specific conditions of participation necessary for health and safety, the Secretary would consult with appropriate governmental agencies and private organizations. The bill specifically requires consultation with appropriate State and local agencies and national listing or accrediting bodies. Your committee would expect that the Secretary would consult with the Joint Commission on the Accreditation of Hospitals as well as with associations of providers of services. Such consultations should be helpful in the development of policies, operational procedures and administrative arrangements of mutual satisfaction to all parties interested in the basic and supplementary plans. Such consultation would provide additional assurance that varying conditions of local and national significance are taken into account.

(3) Agreements to participate

An eligible hospital, extended care facility or home health agency could participate in the programs if it filed with the Secretary an agreement not to charge any beneficiary for covered services for which

payment would be made under the program and to make adequate provision for refund of erroneous charges. Of course, a provider could bill a beneficiary for deductible and coinsurance amounts, for the first 3 pints of blood furnished him during a spell of illness, and for the portion of the charge for a private room or services supplied at the patient's request and not paid for under the program.

An agreement could be terminated by either the provider of services or the Secretary of Health, Education, and Welfare. Beneficiaries would be protected from an abrupt termination of an agreement by a provider by the requirement that notice must be given by the provider to the Secretary and to the public. The length of time between the notice and the point at which the termination becomes effective may be specified in regulations (but the length of time cannot be longer than 6 months).

The Secretary could terminate an agreement only after reasonable notice and only if the provider (a) does not comply with the provisions of the agreement or of the law and regulations, (b) is no longer eligible to participate, or (c) fails to provide data needed to determine what benefit amounts are payable or refuses access to financial records for verification of bills. The Secretary would be required to give reasonable notice and opportunity for hearing to a provider of services before making a final determination that the provider does not qualify to participate under the program or before terminating an agreement with the provider. The final administrative decision is subject to judicial review.

(4) Role of the States

Your committee's bill provides for State agencies, operating under an agreement with the Secretary, to determine whether a provider of services—a hospital, extended care facility or home health agency—meets the conditions for participation in the program, and having determined that the provider meets the conditions, to certify the fact to the Secretary. The Secretary would be required to use the services of State health departments or other appropriate State or local agencies in this way wherever the State agency is able and willing to perform this administrative function. In addition, the Secretary would be authorized to use such agencies for the following additional functions:

(a) Rendering consultative services to providers to assist them to establish and maintain necessary fiscal records and otherwise to meet the conditions for participation and to provide information necessary to derive operating costs so as to determine amounts to be paid for the providers' services;

(b) Rendering consultative services to providers and medical societies to assist in the establishment and testing of utilization review procedures.

To illustrate a consultative function a State agency could perform to assist providers to qualify, a State agency could assist an extended care facility to establish a transfer agreement with a participating hospital.

The Secretary could select also either public or private organizations participating in administration of the programs to perform the consultative functions mentioned in (a) and (b), above. This would enable him to select the organization which he finds can most capably carry out these functions in the specific situation.

State agencies would be reimbursed for the costs of activities they perform in the program. As in the cooperative arrangements with State agencies in the social security disability program, reimbursement to State agencies for hospital insurance benefits activities would meet the agency's related costs of administrative overhead as well as of staff. In recognition of the need for coordination of the various programs in the States that have to do with payment for health care, quality of care, and the distribution of health services and facilities, the Federal Hospital Insurance Trust Fund would pay a fair share of the State agency's costs attributable to planning and coordination of the functions to be performed under the terms of the agreements, with those other activities for which the agency is responsible which relate to public and private programs for the provision of health services similar to those for which payment may be made under the proposed program.

(5) Role of public or private organizations

Your committee's bill provides a considerable role for the participation of private organizations in the administration of both the hospital insurance plan and the supplementary plan.

Under the hospital insurance plan, groups of providers, or associations of providers on behalf of their members, could nominate a national, State, or other public or private agency or organization which they wished to have serve as a fiscal intermediary between themselves and the Federal Government. While it is expected that most providers would want to nominate a private organization, the bill would also permit nomination of a public agency (a State public health agency, for example) by providers which wished to have such an agency serve as fiscal intermediary.

A member of an association whose nominated organization or agency had been selected as a fiscal intermediary could elect to receive payment from another intermediary which had been selected (provided that the other organization or agency agrees) or could elect to deal directly with the Secretary.

The organization or agency serving as a fiscal intermediary under Part A would, under agreement with the Secretary, determine the amount of payments due upon presentation of provider bills and make the payments. The Secretary would be permitted to enter into agreement with a nominated organization only if he finds that this would be consistent with effective and efficient administration and that the organization is able and willing to assist in the application of safeguards against unnecessary utilization of covered services, and only if the organization agrees to furnish him with such of the information it gathers in carrying out the agreement as he finds necessary. The agreement may include provision for the agency or organization to perform one or more of certain administrative duties other than the payment function. These would include providing consultative services to assist providers to establish and maintain necessary fiscal records and otherwise to qualify as providers of services, serving as a center for communicating with providers, making audits of provider records, and performing related functions. The Government would provide advances of funds to the agencies or organizations for purposes of benefit payments and as a working fund for administrative expenses, subject to account and settlement on a cost-incurred basis.

Your committee believes that benefits under the supplementary health insurance benefits program in Part B should be administered by the private sector. This form of administration is particularly appropriate for the supplementary plan because of the benefits the plan would provide in the case of physicians' services. Private insurers, group health plans, and voluntary medical insurance plans have great experience in reimbursing physicians.

The bill requires the Secretary, to the extent possible, to enter into contracts with carriers under which the carriers would perform specified administrative functions or, to the extent provided in the contracts, secure the performance of these functions by other organizations. These functions include: Determining the amount of payments due providers, and making the payments; auditing records of providers; determining whether providers meet the utilization review requirements under the program; assisting providers to develop procedures relating to utilization practices, and studying the effectiveness of such procedures; assisting in the application of safeguards against unnecessary utilization of covered services and in the establishment of review groups outside hospitals; serving as a channel of communication of information relating to the program's administration; and otherwise assisting in the administration of the supplementary plan.

The Secretary would be permitted to enter into contracts with carriers without regard to provisions of law relating to competitive bidding. However, he could enter into such a contract only if he found that the carrier would perform efficiently and effectively and if the carrier met such requirements as to financial responsibility, legal authority, and such other matters as the Secretary found pertinent. It is your committee's intent that the Secretary shall, to the extent possible, enter into contracts with a sufficient number of carriers, selected on a regional or other geographical basis, to permit comparative analysis of their performance. The contracts would have to provide that the carrier would take action to assure that the charges and costs of services for which the supplementary plan may make payment are reasonable. The carrier would also have to maintain such records and furnish such information and reports as the Secretary finds necessary and, in addition, would have to establish procedures for fair review of beneficiary complaints regarding disallowed requests for payment and requests where the amount of payment is in controversy.

The contracts would be for a term of at least 1 year, and could be made automatically renewable. A contract would provide for payment of the carrier's cost of administration (including advances of funds for such purposes), as the Secretary determined to be necessary and proper for carrying out the functions covered by the contract. The Secretary could terminate a contract, after reasonable notice and opportunity for a hearing, if he found that the carrier had failed to substantially carry out the contract or was carrying it out in a manner inconsistent with the efficient administration of the supplementary health insurance program.

The bill broadly defines a carrier with which the Secretary could contract as a voluntary association, corporation, partnership, or other nongovernmental organization lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance

policies or contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier. The definition would specifically include a health benefits plan duly sponsored or underwritten by an employee organization. With respect to hospitals, extended care facilities, and home health agencies, the definition also includes a public or private organization which is nominated by providers of services and which participates in administration of the hospital insurance plan. In addition, a State welfare agency which buys into the program for aged welfare recipients could act as the carrier for its recipients (if it met the other conditions of participation as a carrier).

(6) *Appeals*

Your committee's bill provides for the Secretary to make determinations, under both the hospital insurance plan and the supplementary plan, as to whether individuals are entitled to hospital insurance benefits or supplementary health insurance benefits and for hearings by the Secretary and judicial review where an individual is dissatisfied with the Secretary's determination. Hearings and judicial review are also provided for where an individual is dissatisfied with a determination as to the amount of benefits under the hospital insurance plan if the amount in controversy is \$1,000 or more. (Under the supplementary plan, carriers, not the Secretary, would review beneficiary complaints regarding the amount of benefits.) Hospitals, extended care facilities, and home health agencies would be entitled to hearing and judicial review if they are dissatisfied with the Secretary's determination regarding their eligibility to participate in the program.

4. ACTUARIAL COST ESTIMATES FOR THE HOSPITAL INSURANCE SYSTEM

(a) *Summary of actuarial cost estimates*

The hospital insurance system established by your committee's bill has an estimated cost for benefit payments and administrative expenses that is in long-range balance with contribution income. It is recognized that the preparation of cost estimates for hospitalization and related benefits is much more difficult and is much more subject to variation than cost estimates for the cash benefits of the old-age, survivors, and disability insurance system. This is so not only because the hospital insurance program would be newly established, with no past operating experience, but also because of the greater number of variable factors involved in a service-benefit program than in a cash-benefit one. However, your committee believes that the cost estimates are made under very conservative assumptions with respect to all foreseeable factors.

It is essential, in the view of your committee, that the developing operations of this new program should be carefully studied as they occur in the immediate future, so that the Congress and the executive branch can be kept as well informed as possible and as quickly as is feasible. Under these circumstances, your committee agrees with the suggestion which has been made that there should be a small continuing actuarial sample (of perhaps 0.1 percent of all eligible individuals), whose experience can be followed as promptly and as thoroughly as if the system related to only about 20,000 persons (under which circumstances, it would be possible to make many complete studies

of experience as rapidly as it develops, without the disadvantages from a time standpoint of handling the vast amount of data that arises for the millions of persons protected by the full program). In this connection, it will be essential for carriers involved in the processing and payment of claims to supply the necessary actuarial information promptly and in adequate fashion for the actuarial analyses to be made.

(b) *Financing policy*

(1) *Financing basis of committee bill*

The contribution schedule contained in your committee's bill for the hospital insurance program and the corresponding maximum earnings bases are as follows:

Calendar year	Earnings base	Employer-employee rate (percent)	Self-employed rate (percent)
1966.....	\$5,600	0.7	0.35
1967 to 1970.....	5,600	1.0	.50
1971 to 1972.....	6,600	1.0	.50
1973 to 1975.....	6,600	1.1	.55
1976 to 1979.....	6,600	1.2	.60
1980 to 1986.....	6,600	1.4	.70
1987 and after.....	6,600	1.6	.80

The hospital insurance program would be completely separate from the old-age, survivors, and disability insurance system in several ways, although the earnings base would be the same under both programs. *First*, the schedules of tax rates for old-age, survivors, and disability insurance and for hospital insurance are in separate subsections of the Internal Revenue Code (unlike the situation for old-age and survivors insurance as compared with disability insurance, where there is a single tax rate for both programs, but an allocation thereof into two portions). *Second*, the hospital insurance program has a separate trust fund (as is also the case for old-age and survivors insurance and for disability insurance) and, in addition, has a separate Board of Trustees from that of the old-age, survivors, and disability insurance system. *Third*, the bill provides that income tax withholding statements (forms W-2) shall show the proportion of the total contribution for old-age, survivors, and disability insurance and for hospital insurance that is with respect to the latter. *Fourth*, the hospital insurance program would cover railroad employees directly in the same manner as other covered workers, and their contributions would go directly into the hospital insurance trust fund and their benefit payments would be paid directly from this trust fund (rather than directly or indirectly through the railroad retirement system), whereas these employees are not covered by old-age, survivors, and disability insurance (except indirectly through the financial interchange provisions). *Fifth*, the financing basis for the hospital insurance system would be determined under a different approach than that used for the old-age, survivors, and disability insurance system, reflecting the different natures of the two programs (by assuming rising earnings levels and rising hospitalization costs in future years instead of level-earnings assumptions and by making the estimates for a 25-year period rather than a 75-year one).

(2) *Self-supporting nature of system*

Just as has always been the case in connection with the old-age, survivors, and disability insurance system, your committee has very carefully considered the cost aspects of the proposed hospital insurance system. In the same manner, your committee believes that this program should be completely self-supporting from the contributions of covered individuals and employers (the transitional uninsured group that would be covered by this program would have their benefits, and the resulting administrative expenses, completely financed from general revenues, according to the provisions of the bill). Accordingly, your committee very strongly believes that the tax schedule in the law should make the hospital insurance system self-supporting over the long range as nearly as can be foreseen, as well as actuarially sound.

(3) *Actuarial soundness of system*

The concept of actuarial soundness as it applies to the hospital insurance system is somewhat similar to that concept as it applies to the old-age, survivors, and disability insurance system (see discussion of this topic in a following section), but there are important differences.

One major difference in this concept as it applies between the two different systems is that cost estimates for the hospital insurance program should desirably be made over a period of only 25 years in the future, rather than 75 years as in connection with the old-age, survivors, and disability insurance program. A shorter period for the hospital insurance program is necessary because of the greater difficulty in making forecast assumptions for a service benefit than for a cash benefit. Although there is reasonable likelihood that the number of beneficiaries aged 65 and over will tend to increase over the next 75 years when measured relative to covered population (so that a period of this length is both necessary and desirable for studying the cost of the cash benefits under the old-age, survivors, and disability insurance program), it is far more difficult to make reasonable assumptions as to the trends of medical care costs and practices for more than 25 years in the future.

In starting a new program such as hospital insurance, it seems desirable to your committee that the program should be completely in actuarial balance. In order to accomplish this result, your committee has developed a contribution schedule that will meet this requirement, according to the underlying cost estimates.

(c) *Hospitalization data and assumptions*

(1) *Past increases in hospital costs and in earnings*

Table A presents a summary comparison of the annual increases in hospital costs and the corresponding increases in wages that have occurred since 1954 and up through 1963.

TABLE I.—*Comparison of annual increases in hospitalization costs and in earnings*

[In percent]

Calendar year	Increase over previous year	
	Average wages in covered employment	Average daily hospitalization costs
1955.....	3.8	6.3
1956.....	5.7	4.5
1957.....	5.5	7.7
1958.....	3.3	8.6
1959.....	3.3	6.8
1960.....	4.3	6.8
1961.....	3.1	8.5
1962.....	4.2	5.3
1963.....	2.4	5.6
Average ¹	4.0	6.7

¹ Rate of increase compounded annually that is equivalent to total relative increase from 1954 to 1963.

The annual increases in earnings are based on those in covered employment under the old-age, survivors, and disability insurance system as indicated by first quarter taxable wages, which by and large are not affected by the maximum taxable earnings base. The data on increases in hospitalization costs are based on a series of average daily costs (including not only room and board, but also other charges), prepared by the American Hospital Association.

The annual increases in earnings have fluctuated somewhat over the 10-year period, although there have not been very large deviations from the average annual rate of 4.0 percent; no upward or downward trend over the period is discernible. The annual increases in hospital costs likewise have fluctuated from year to year around the average annual rate of 6.7 percent; the increases in the last 2 years were relatively low as compared with previous years.

Hospital costs then have been increasing at a faster rate than earnings. The differential between these two rates of increase has fluctuated widely, being as high as somewhat more than 5 percent in some years and as low as a negative differential of about 1 percent in 1956 (with the next lowest differential being a positive one of about 1 percent in 1962). Over the entire 10-year period, the differential between the average annual rate of increase in hospital costs over the average annual rate of increase in earnings was 2.7 percent.

Your committee was advised by the Department of Health, Education, and Welfare that, in the future, earnings are estimated to increase at a rate of about 3 percent per year. It is much more difficult to predict what the corresponding increase in hospital costs will be. It would appear that, at the least, hospital costs would increase about 2 percent per year more than earnings for a few years and that, at the most, this differential rate would be 3 percent per year. It is recognized, of course, that these "minimum" and "maximum" assumptions result in a relatively wide spread in the cost estimates for hospital insurance proposals if the estimates are carried out for a number of years into the future.

(2) *Assumptions underlying original cost estimates for the administration's bill, H.R. 3920 and S. 880, 88th Congress (the "King-Anderson" bill)*

By way of background to the development of the cost estimates for the hospital insurance system that would be established by your committee's bill, there follows a discussion of cost estimates on the administration's proposals in the 88th Congress and in this Congress.

The actuarial cost estimates for H.R. 3920 and S. 880, 88th Congress, made at the time of its introduction in 1963 were presented in detail—as to assumptions, methodology, and results—in Actuarial Study No. 57 of the Social Security Administration.

In considering the hospitalization-benefit costs in conjunction with a level-earnings assumption for the future, it is sufficient for the purposes of long-range cost estimates merely to analyze possible future trends in hospitalization costs relative to covered earnings. Accordingly, any study of past experience of hospitalization costs should be made on this relative basis. The actual experience in recent years has indicated, in general, that hospitalization costs have risen more rapidly than the general earnings level, with the differential being in the neighborhood of 3 percent per year—2.7 percent in the last 10 years.

A major consideration in making cost estimates for hospitalization benefits, then, is how long and to what extent this tendency of hospital costs to rise more rapidly than the general earnings level will continue in the future, and whether or not it may in the long run be counterbalanced by a trend in the opposite direction. Some factors to consider are the relatively low wages of hospital employees (which have been rapidly "catching up" with the general level of wages and obviously may be expected to "catch up" completely at some future date, rather than to increase indefinitely at a more rapid rate than wages generally) and the development of new medical techniques and procedures, with resultant increased expense.

In connection with this factor, there are possible counterbalancing factors. The higher costs involved for more refined and extensive treatments may be offset by the development of out-of-hospital facilities, shorter durations of hospitalization, and less expense for subsequent curative treatments as a result of preventive measures. Also, it is possible that at some time in the future, the productivity of hospital personnel will increase significantly as the result of changes in the organization of hospital services or for other reasons, so that, as in other fields of economic activity, the general wage level might increase more rapidly than hospitalization prices in the long run.

Perhaps the major consideration in making and in presenting these actuarial cost estimates for hospitalization benefits is that—unlike the situation in regard to cost estimates for the monthly cash benefits, where the result is the opposite—an unfavorable cost result is shown when total earnings levels rise, unless the provisions of the system are kept up to date (insofar as the maximum taxable earnings base and the dollar amounts of any deductibles are concerned). The reason for this result is that in Actuarial Study No. 59 the fundamental actuarial assumption was made that hospitalization costs would rise at the same rate over the long run as the total earnings level, whereas the contribution income would rise less rapidly than the total earnings level unless the earnings base is kept up to date. Under these condi-

tions, it is necessary that the base be kept up to date with the changes in the general level of earnings, since contributions depend on the covered earnings level, and this level is dampened if the earnings base is not raised as earnings go up. Accordingly, it was necessary in the actuarial cost estimates for hospitalization benefits in Actuarial Study No. 59 to assume either that earnings levels will be unchanged in the future or that, if wages continue to rise (as they have done in the past), the system will be kept up to date insofar as the earnings base and the deductibles are concerned.

The basic assumption underlying the actuarial cost estimates in Actuarial Study No. 57 was that the relationship between earnings and hospital costs would, on the average, be the same into the future as in the 1961 experience. Alternatively and equivalently, these assumptions meant that earnings and hospital costs will rise, on the average, at the same rate in the future and that the earnings base will be adjusted proportionately with changes in the earnings level.

(3) *Alternative assumptions for hospitalization-benefits cost estimates*

One alternative basis for the assumptions that have just been discussed would assume the continuation into the long-range future of recent trends in the relationship between hospitalization costs and the general wage level, while at the same time assuming that there would be no change in the maximum earnings base under the system.

In the recent past, the general earnings level has increased at a rate of about 4 percent a year, while hospital costs have risen about 7 percent a year, so that there is a differential of about 3 percent. Assuming the continuation of these trends into the *indefinite future* and assuming, at the same time, no change in the maximum earnings base would have the following effects:

(1) Eventually hospitalization costs would exceed 100 percent of the earnings of all workers in the country—let alone, of taxable earnings.

(2) Virtually everyone entitled to cash benefits under the system would have the maximum benefit prescribed under the law, since they would have their benefits figured on the maximum creditable earnings. The earnings of the lowest paid part-time workers would eventually rise to the present maximum earnings base.

(3) The cash benefits of the system would be only a very small proportion of a person's previous earnings.

(4) As a percentage of taxable payroll, the cost of the cash-benefits portion of the system would be considerably lower than it is presently estimated to be—to the extent of about $1\frac{1}{4}$ percent of taxable payroll.

Such an assumption was not used in the cost estimates because it is considered to be completely unrealistic—and could be considered an “impossible” one. It is inconceivable that hospital prices would rise indefinitely at a rate faster than earnings because eventually individuals—even currently employed workers, let alone older persons—could not afford to go to a hospital under such cost circumstances.

As a numerical example, consider a full-time male worker now earning the “typical” amount of \$20 per day, or \$5,200 per year. The average daily cost for hospitalization (including not only room and

board, but also other charges) for persons of all ages is about \$40, currently, or twice the average daily wage. If wages increase 4 percent per year, and if hospital costs increase 7 percent per year—indeinitely into the future—then the following situation will occur:

Item	At present	In 20 years	In 50 years
Average daily wage.....	\$20	\$43.82	\$142.13
Average daily hospitalization cost.....	\$40	\$154.79	\$1,178.28
Ratio of hospital cost to average daily wage (percent).....	200	353	829
Proportion of wage covered by \$5,600 base (percent).....	100	54	16

Consideration of the foregoing figures indicates that, whereas the cost of a hospital day now averages about 2 days' wages, then in 50 years if the assumed trends take place, the cost of a hospital day will be over 8 days' wages. Quite obviously, it is an untenable assumption that there can be a sizable differential between the increase in hospitalization costs and the increase in earnings levels that will continue for a longer period into the future.

(4) *Assumptions underlying original cost estimates for the administration's bill, H.R. 1 and S. 1, 89th Congress (the "King-Anderson" bill)*

The Advisory Council on Social Security Financing, which was appointed in 1963 and completed its work by the end of 1964, considered the subject of hospitalization benefits and made significant recommendations in this field that were quite similar to the corresponding provisions contained in the administration's bill, H.R. 1 and S. 1, 89th Congress, introduced in January 1965. Further details on the recommendations of the Advisory Council and on the cost assumptions that it suggested may be found in its report "The Status of the Social Security Program and Recommendations for Its Improvement" (app. V, 25th Annual Report of the Board of Trustees, H. Doc. No. 100, 89th Cong.).

The Advisory Council stressed that the assumptions used in estimating hospital insurance costs should be conservative (i.e., where judgment issues arise, they should be resolved in a direction that would yield a higher cost estimate). The assumptions suggested by the Advisory Council were that the estimated 1965 hospitalization costs should be assumed to increase in the future in relation to total earnings rates by a net differential of 2.7 percent per year for the first 5 years after 1965, with this differential then being assumed to decrease to zero over the next 5 years; during the following 5 years, the differential is assumed to reverse, and after 1980 earnings are assumed to rise at an annual rate that is 0.5 percent greater than the increase in hospitalization costs.

The cost estimates made for H.R. 1 and S. 1 (as contained in Actuarial Study No. 59 of the Social Security Administration) were on the same basis as to hospitalization-cost assumptions as recommended by the Advisory Council. The long-range cost estimates were developed on the basis that the base figure for average daily hospitalization costs would be 1963 (since the cost estimates for both the cash benefits and the hospitalization benefits are founded on this basic assumption). This, in turn, meant that there was also the

coordinate assumption that the earnings base would, in the future, keep up to date with what \$5,600 represented in 1963.

(5) *Assumptions as to relative trends of hospitalization costs and earnings underlying cost estimate for committee bill—H.R. 6675*

As indicated previously, your committee very strongly believes that the financing basis of the new hospital insurance program should be developed on a conservative basis. For the reasons brought out previously, the cost estimates should not be developed on a level-earnings basis, but rather they should assume dynamic conditions as to both earnings levels and hospitalization costs. Accordingly, it seems appropriate to make cost projections for only 25 years in the future and to develop the financing necessary for only this period (but with a resulting trust fund balance at the end of the period equal to about 1 year's disbursements). Although the trend of beneficiaries aged 65 and over relative to the working population will undoubtedly move in an upward direction after 25 years from now, it seems impossible to predict what the trend of medical costs and what hospital-utilization and medical-practice trends will be in the distant future.

Accordingly, for the purposes of the cost estimates in this report, the assumptions as to the relative trend of hospitalization costs as compared with the general earnings level have been modified somewhat as compared with the relatively conservative assumptions recommended by the Advisory Council. The same differential of hospital costs over earnings for the first 10 years is used, but thereafter the assumption is made that these two elements increase at the same rate (rather than having a negative one-half of 1 percent annual differential, as in the Advisory Council recommendations). In other words, the basis of the hospitalization-cost trends used in the cost estimates of this report are on a more conservative basis than recommended by the Advisory Council and, in fact, are more conservative than those used by the insurance business for its estimates for proposals of this type.

(6) *Assumptions as to hospital utilization rates underlying cost estimates for committee bill—H.R. 6675*

It should be pointed out that the hospital utilization assumptions for the cost estimates prepared by the Social Security Administration and also those in this report have always been founded on the hypothesis that current practices in this field will not change relatively more in the future than past experience has indicated. In other words, no account is taken of the possibility that there will be a drastic change in philosophy as to the best medical practices, so as, for example, to utilize in-hospital care to a much greater extent than is now the case.

The hospital utilization rates used for the cost estimates for the various past proposals (H.R. 3920 and S. 880, 88th Congress; the Advisory Council plan; and H.R. 1 and S. 1, 89th Congress) were the same in all instances. In view of the fact that testimony of the insurance business and the Blue Cross stated their belief that higher utilization would develop (actually, by as much as 40 percent higher in the early years of operation), your committee has adopted higher utilization rates than those used previously by the Social Security Administration. The increase in the early-year utilization rates is about 20 percent. Half of this can be attributed to changing the

previous assumption of low-cost utilization rates in the early years to the assumption of the intermediate-cost rates then; the latter were previously used only after the program would be in operation for a few years and the beneficiaries would have better knowledge of the benefits available. The other half of the increase in the utilization rates can be said to represent a basic adjustment upward for all future years, which can be viewed as a safety factor.

In other words, the current estimates can be considered to be high-cost ones, as compared with the intermediate-cost ones formerly used by the Social Security Administration. Another factor that may be used to justify the higher utilization rates used in these cost estimates is the somewhat greater amount of hospitalization which might result from the availability of the physicians' services benefits for in-hospital cases made available under the supplementary health insurance benefits program contained in your committee's bill.

(7) *Assumptions as to hospital per diem rates underlying cost estimates for committee bill—H.R. 6675*

The average daily cost of hospitalization that is used in these cost estimates is computed on the same basis as the corresponding figures in Actuarial Study No. 59 of the Social Security Administration. These per diem costs were in close agreement with what the Blue Cross testimony indicated, although some 13 percent below the estimates of the insurance business. The reason for the latter differential is that the insurance business did not make as large an allowance for a lower average daily cost for persons aged 65 and over and for hospital expenses that are not related to inpatients. The only significant change in the average daily hospitalization cost figures was a reduction by about 4 percent to allow for the exclusion from the hospital insurance system that would be established by your committee's bill of the in-hospital costs arising from the professional services of radiologists, anesthesiologists, pathologists, and physiatrists (the costs for such services would be covered under the supplementary health insurance benefits plan).

(d) *Results of cost estimates*

(1) *Summary of cost estimates for H.R. 1 and S. 1, 89th Congress, under various cost assumptions*

Table B summarizes the cost estimates that would be made for H.R. 1 and S. 1, 89th Congress (the King-Anderson bill), under various cost assumptions that have been used in the past, and also under those that are being used for your committee's bill. This analysis is made, with a single plan as the base point, so as to show the effect of the various assumptions. The variations shown arise from changes in a number of the cost factors—the relative trend of hospitalization costs as compared with earnings; the period over which the cost estimates are made, and whether static or dynamic assumptions are involved; and the hospital utilization rates.

In all the previous cost estimates, it was assumed that the maximum taxable earnings base would be kept up to date, by periodic changes, with changes in the general earnings level, and also that the same would be true of any deductibles. In regard to the latter element, many of the proposals had provisions calling for increases in the deductible amounts as hospital costs increase in the future so that the condition was thus satisfied; this is the case in connection with the hospital and outpatient diagnostic deductibles in your committee's bill.

With regard to the assumption that the earnings base would be kept up to date in the future, your committee believes that this is not a conservative assumption, since it seems to bind future Congresses into taking action in order to maintain the actuarial soundness of the hospital insurance system. It should be emphasized that the actuarial soundness of the cash benefits program under the old-age, survivors, and disability insurance system does not at all depend upon an assumption of the earnings base being adjusted upward when wages rise (but rather, on the contrary, the actuarial status of the system is improved under such circumstances). Accordingly, although your committee believes that, under the likely conditions of rising wages over the next 25 years, the earnings base will be adjusted upward beyond the two increases contained in your committee's bill (from the present \$4,800 to \$5,600 in 1966, and to \$6,600 in 1971), the conservative assumption should be made for the purposes of the actuarial cost estimates that no further increases will occur after 1971.

TABLE B.—*Summary of cost estimates for hospital insurance benefits of H.R. 1 and S. 1, 89th Congress, under various cost assumptions*

Assumptions as to earnings base	Assumptions as to relative trends of hospitalization costs and earnings	Estimated level-cost ¹
COST ESTIMATES PREPARED ON LONG-RANGE LEVEL-EARNINGS ASSUMPTIONS		
(1) Keeps up to date with what \$5,600 was in 1963.	Over the long range, hospitalization costs and earnings increase at same rate from 1961 on.	0.67% (basis of Actuarial Study No. 57, 1963).
(2) Keeps up to date with what \$5,600 was in 1963.	Past experience projected to 1965; in next 5 years, hospitalization costs, rise more rapidly than earnings—by a total differential of 10%; thereafter, hospitalization costs and earnings rise at same rate.	0.81% (basis of cost estimates developed for 1964 legislation).
(3) Keeps up to date with what \$5,600 was in 1963.	Past experience projected to 1965; hospitalization costs rise more rapidly than wages by 2.7% for 5 years; then this differential is reduced to zero in next 5 years and after 1975 wages rise more rapidly than hospitalization costs by $\frac{1}{4}$ % per year.	0.84% (basis of cost estimates for Advisory Council and in Actuarial Study No. 59, 1965).
(4) Keeps up to date with what \$5,600 was in 1963.	Past experience projected to 1965; hospitalization costs rise more rapidly than wages by 2.7% for 5 years; then, this differential is reduced to zero in next 5 years; after 1975, hospitalization costs and wages increase at same rate.	0.87%.
(5) Keeps up to date with what \$5,600 would be in 1966.	Same as in (4).....	0.90%.
COST ESTIMATES PREPARED ON LONG-RANGE RISING-EARNINGS ASSUMPTIONS		
(6) Same as in (5).....	Same as in (4).....	0.96%.
(7) Remains at \$5,600 through 1970; brought up to date by increase to \$6,600 in 1971 and increased correspondingly every 5th year thereafter.	Same as in (4).....	0.98%.
(8) Remains at \$5,600 through 1970; increases to \$6,600 in 1971 and then remains constant.	Same as in (4).....	1.09%. ²

¹ Except for items (1) and (2), which are on a perpetuity basis, the figures are for the level-cost over a 25-year period, expressed as a percentage of taxable payroll; includes margin so that trust fund balance at end of period equals the disbursements for that year.

² All the cost estimates for items (1) to (8) are based on the hospital utilization rates of Actuarial Study No. 59 of the Social Security Administration. The level-cost for item (8) would be increased to 1.21% under the hospital utilization rates of the estimates of this report.

(2) *Level-costs of hospitalization and related benefits*

As shown in footnote 2 of table B, the level-cost of the hospital benefits that would be provided under H.R. 1 and S. 1, 89th Congress, is 1.21 percent of taxable payroll, under the assumptions that the earnings base would be the same as in your committee's bill and would not change after 1971, and that both hospitalization costs and general earnings will continue to rise during the entire 25-year period considered in the cost estimates. The corresponding level-cost of the hospital and related benefits in your committee's bill is 1.23 percent of taxable payroll. The small difference arises from several factors. A higher cost arises for your committee's bill because the self-employed contribute on a lower rate basis (i.e., at the employee rate instead of $1\frac{1}{2}$ times the employee rate), because there are more insured persons (due to the transitional insured status provisions for certain persons aged 72 and over), and because of the direct coverage of railroad workers (more thorough consideration of the effect of the financial interchange provisions in the previous proposals has now been given). On the other hand, there is a lower cost under your committee's bill because of the exclusion of all in-hospital physician services and of pre-hospital home health services, but this only partially offsets the factors mentioned in the previous sentence.

The level-equivalent of the contribution schedule in your committee's bill (as described previously) is also 1.23 percent of taxable payroll. Accordingly, these estimates indicate that the hospital insurance program is in exact actuarial balance under the assumptions made (and described previously).

The estimated level-cost of the hospital and related benefits of 1.23 percent consists predominantly of the cost of the hospital benefits. It does not seem feasible to attempt to subdivide the cost for the hospital benefits and the extended care facility benefits between these two categories. In the early years, virtually all of such costs will be for hospital benefits. Perhaps only about \$25 to \$50 million will be expended in 1967 for extended care facility benefits. In later years, it seems quite possible that greater use of post-hospital extended care services will be made, thus tending to reduce the use of hospitals. From a cost standpoint then, it seems desirable to consider hospital benefits and extended care facility benefits in combination, and it is estimated that the level-cost therefor is 1.19 percent of taxable payroll. The level-cost of outpatient hospital diagnostic benefits is estimated at 0.01 percent of taxable payroll, with the cost in the first full year of operations being about \$10 million. Finally, the estimated level-cost of the post-hospital home health benefits is 0.03 percent of taxable payroll, a figure that allows for a considerable expansion of these services in the future (with the cost in the first full year of operations being estimated at less than \$10 million).

As indicated previously, one of the most important basic assumptions in the cost estimates presented herein is that the earnings base is assumed to remain unchanged after it increases to \$6,600 in 1971, even though for the remainder of the period considered (up to 1990) the general earnings level is assumed to rise at a rate of 3 percent annually. If the earnings base does rise in the future to keep up to date with the general earnings level, then the contribution rates required would be lower than those scheduled in your committee's

bill. In fact, if this were to occur, the steps in the contribution schedule beyond the combined employer-employee rate of 1.1 percent would not be needed. Furthermore, under the foregoing conditions, if the hospital utilization experience followed the intermediate-cost assumptions made previously in Actuarial Study No. 59 of the Social Security Administration (increased by 10 percent for the estimates presented in this report), and if all other conditions (such as the relationship of hospitalization costs and general earnings) developed as they are set forth in the assumptions, then it is possible that the combined employer-employee contribution rate would not have to increase beyond 1.0 percent.

(3) Number of persons protected on July 1, 1966

It is estimated that on July 1, 1966, the total population of the United States (including American Samoa, Guam, Puerto Rico, and the Virgin Islands) who are aged 65 and over will be 19.10 million (after allowance for underenumeration in the census counts and in population projections based thereon).

The total number of such persons who are estimated to be eligible for the hospital and related benefits on the basis of insured status under the old-age, survivors, and disability insurance system and the railroad retirement system is 16.95 million. Of the remaining 2.15 million, about 2.00 million are estimated to be eligible for the hospital and related benefits under the transitional provision on eligibility of presently uninsured individuals, as contained in your committee's bill. The remaining 150,000 persons are not eligible for hospital and related benefits because they are active or retired employees who are eligible (or had the opportunity to be eligible) for more comprehensive benefits under the Federal Employees Health Benefits Act of 1959, because they are alien residents who do not meet the residence requirements, or because they are subversives.

The cost for the 2.00 million persons who would be blanketed in for the hospital and related benefits is met from the General Treasury (with the financial transactions involved passing through the hospital insurance trust fund). The costs so involved, along with the financial transactions, are not included in the preceding cost analysis or in the following discussions of the progress of the hospital insurance trust fund. A later portion of this section, however, discusses these costs for the blanketed-in group.

(4) Future operations of hospital insurance trust fund

Table C shows the estimated operation of the hospital insurance trust fund under your committee's bill. According to this estimate, the balance in the trust fund would grow steadily in the future, increasing from about \$560 million at the end of 1966 to \$1.9 billion 5 years later. Over the long range, the trust fund would build up steadily, reaching \$9.9 billion in 1990 (representing the benefit outgo for 1.1 years at the level of that time).

TABLE C.—*Estimated progress of hospital insurance trust fund*

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Interest on fund	Balance in fund at end of year
1966.....	\$1,578	\$982	¹ \$50	\$17	\$562
1967.....	2,601	2,192	66	20	925
1968.....	2,790	2,391	72	34	1,286
1969.....	2,879	2,607	78	45	1,525
1970.....	2,983	2,840	85	50	1,633
1971.....	3,327	3,055	92	55	1,868
1972.....	3,488	3,280	98	60	2,038
1973.....	3,929	3,516	105	68	2,414
1974.....	4,120	3,760	113	77	2,738
1975.....	4,267	4,028	121	84	2,950
1980.....	6,123	5,276	158	140	5,018
1985.....	7,038	6,823	205	236	7,681
1990.....	9,030	8,754	263	306	9,948

¹ Including administrative expenses incurred in 1965.

NOTE.—The transactions relating to the noninsured persons, the costs for whom is borne out of the general funds of the Treasury, are not shown in the above figures.

(e) Cost estimate for hospitalization benefits for noninsured persons paid from general funds

Your committee's bill would provide hospitalization and related benefits not only for beneficiaries of the old-age, survivors, and disability insurance system and the railroad retirement system, but also for most persons aged 65 and over in 1966 (and for many of those attaining this age in the next few years) who are not insured under either of these two social insurance systems. Such benefit protection would be provided to any person aged 65 and over on July 1, 1966, who is not eligible as an old-age, survivors, and disability insurance or railroad retirement beneficiary and who (a) is not an employee of the Federal Government or a retired Federal employee eligible (or who had the opportunity to be eligible) for health benefits under the Federal Employees Health Benefits Act of 1959, (b) is not a member of a subversive organization and has not been convicted of subversive activities, and (c) is a citizen or has had at least 10 years of continuous residence.

Persons meeting such conditions who attain age 65 before 1968 also would qualify for the hospitalization benefits, while those attaining age 65 after 1967 must have some old-age, survivors, and disability insurance or railroad retirement coverage to qualify—namely, 3 quarters of coverage (which can be acquired at any time after 1936) for each year elapsing after 1965 and before the year of attainment of age 65 (e.g., 6 quarters of coverage for attainment of age 65 in 1968, 9 quarters for 1969, etc.). This transitional provision “washes out” for men attaining age 65 in 1974 and for women attaining age 65 in 1972, since the fully-insured-status requirement for monthly benefits for such categories is then no greater than the special-insured status requirement.

The benefits for the “noninsured” group would be paid from the health insurance trust fund, but with simultaneous reimbursement therefor from the general fund of the Treasury on a current basis.

The estimated cost to the general fund of the Treasury for the hospitalization and related benefits for the noninsured group is as follows for the first 5 calendar years of operation (in millions):

Calendar year:	Cost to General Treasury
1966 (last 6 months).....	\$140
1967.....	275
1968.....	270
1969.....	260
1970.....	250

The cost to the general fund of the Treasury decreases slowly for the closed group involved. Offsetting, in large part, the decline in the number of eligibles blanketed in is the increasing hospital utilization per capita as the average age of the group rises and the increasing hospitalization costs in future years.

5. ACTUARIAL COST ESTIMATES FOR THE VOLUNTARY SUPPLEMENTARY HEALTH INSURANCE BENEFITS SYSTEM

(a) *Summary of actuarial cost estimates*

The supplementary health insurance benefits system that would be established by your committee's bill has an estimated cost for benefit payments incurred and for administrative expenses that would adequately be met during the first 2 years of operation (1966-67) by the individual premium rates prescribed plus the equal matching contributions from the general fund of the Treasury. Both contributions and benefit payments would begin in July 1966. In subsequent years, your committee's bill provides for appropriate adjustment of the premium rates so as to assure that the program will be adequately financed, along with the establishment of sufficient contingency reserves. Although provision is made for an advance appropriation from general revenues to provide a contingency reserve during the period July 1966 through June 1967, it is believed that this will not actually have to be drawn upon, but nonetheless it serves as a desirable safeguard to the financing basis of the program.

Just as in the case of the hospital insurance system, it is essential that the operating experience of a vast new program such as this should be subject to prompt, thorough actuarial review and study. Accordingly, your committee approves of the suggestion that has been made for a small random sample of the eligibles to be maintained on a current basis, so as to permit intensive study by the actuary without the delay that would be inherent in attempting to obtain operating experience data for the entire group of persons covered under the system

(b) *Financing policy*

(1) *Self-supporting nature of system*

Your committee has recommended the establishment of a supplementary health insurance benefits program that can be voluntarily elected, on an individual basis, by virtually all persons aged 65 and

over in the United States. This program is intended to be completely self-supporting from the contributions of covered individuals and from the equal-matching contributions from the general fund of the Treasury. Initially (for the period July 1966 through December 1967), the premium rate is established at \$3 per month, so that the total income of the system per participant per month will be \$6. Persons who do not elect to come into the system at as early a time as possible will generally have to pay a higher premium rate than \$3. Under your committee's bill, the monthly premium rate can be adjusted for future years after 1967 so as to reflect the expected experience, including an allowance for a margin for contingencies. All financial operations for this program would be handled through a separate fund, the supplementary health insurance benefits trust fund.

Your committee's bill also provides for the establishment of an advance appropriation from the General Treasury that will serve as an initial contingency reserve in an amount equal to \$18 (or 6 months' per capita contributions from the General Treasury) times the number of individuals who are estimated to be eligible for participation in July 1966. This amount, which is approximately \$345 million, would be appropriated before July 1, 1966, but it would not actually be transferred to the supplementary health insurance benefits trust fund unless, and until, some of it would be needed. This contingency amount would be available only during the first year of operations (July 1966 through June 1967), and any amounts actually transferred to the trust fund would be subject to repayment of the funds of the Treasury (without interest).

(2) *Actuarial soundness of system*

The concept of actuarial soundness for the old-age, survivors, and disability insurance system and for the hospital insurance system is somewhat different than that for the supplementary health insurance benefits program. In essence, the last system is on a "current cost" financing basis, rather than on a "long-range cost" financing basis. The situations are essentially different because the financial support of the supplementary health insurance benefits system comes from a premium rate that is subject to change from time to time, in accordance with the experience actually developing and with the experience anticipated in the near future. The actuarial soundness of the supplementary health insurance benefits program, therefore, depends only upon the "short-term" premium rates being adequate to meet, on an accrual basis, the benefit payments and administrative expenses over the period for which they are established (including the accumulation and maintenance of a contingency fund).

(c) *Results of cost estimates*

(1) *Cost assumptions*

Only a relatively small amount of data is available in regard to the physician's services and other services that would be covered by the supplementary health insurance benefits system. The cost estimates used in determining the premium rate to be charged to individuals,

along with the matching Government contribution, have utilized data from the experience under the Federal Employees Health Benefits Act of 1959 for persons aged 65 and over, the experience under the Connecticut 65 program, and various information obtained by the National Health Survey conducted on a periodic basis by the Public Health Service of the Department of Health, Education, and Welfare.

The cost estimates have been made on a conservative basis—as seems essential in a newly established program of this type for persons aged 65 and over, most of whom have not previously had such insurance. It is believed that the \$6 total per capita income of the system (from the premiums of the individuals and the matching Government contributions) will be fully adequate to meet the costs of administration and the benefit payments incurred, as well as to build up a relatively small contingency reserve. It is believed that there will be no need to draw upon the advance appropriation that is provided from general revenues.

Two cost estimates have been presented in regard to the possible per capita cost. Under the low-cost estimate, the benefits and administrative expenses will, on an accrual basis, represent about 75 percent of the contribution income, whereas under the high-cost estimate, the corresponding ratio will be almost 100 percent.

In an individual voluntary-election program such as this, it is impossible to predict accurately in advance what proportion of those eligible to participate in the program will actually do so. Accordingly, the cost estimates have been presented on two bases—an assumed 80 percent participation and an assumed 95 percent participation. Both of these estimates assume that virtually all State public assistance agencies will “buy in” for their old-age assistance recipients.

(2) Short-range operations of supplementary health insurance benefits trust fund

Table D presents estimates of the operation of the supplementary health insurance benefits trust fund for the first 2 years of operation, 1966–67. As indicated previously, four sets of estimates are given, under different assumptions as to low-cost and high-cost estimates and low and high participation. A significant balance in the trust fund develops in 1966, because of the lag involved in making benefit payments, since there are the factors of administrative processing and of the deductible that must be met first before any benefits are payable. In this respect, it will be noted that the income from premium payments by individuals will go into the trust fund beginning in the early part of July 1966, and the matching Government contributions will go into the trust fund simultaneously.

Under the low-cost estimates, the trust fund is estimated to have a balance of about \$300 to \$350 million at the end of 1966, and between \$600 and \$700 million at the end of 1967. On the other hand, under the high-cost estimates, the balance in the trust fund at the end of 1966 will be between \$200 and \$250 million, and will remain at substantially this level during 1967.

TABLE D.—*Estimated progress of supplementary health insurance benefits trust fund*
[In millions]

Calendar year	Contributions		Benefit payments	Adminis- trative ex- penses	Interest on fund	Balance in fund at end of year
	Partici- pants	Govern- ment				
	Low cost estimate, 80-percent participation					
1966 ¹	\$275	\$275	\$195	\$65	\$5	\$295
1967.....	560	560	765	75	15	590
	Low-cost estimate, 95-percent participation					
1966 ¹	\$325	\$325	\$230	\$80	\$5	\$345
1967.....	665	665	905	90	20	700
	High-cost estimate, 80-percent participation					
1966 ¹	\$275	\$275	\$260	\$85	\$5	\$210
1967.....	560	560	1,025	95	10	220
	High-cost estimate, 95-percent participation					
1966 ¹	\$325	\$325	\$310	\$100	\$5	\$245
1967.....	665	665	1,220	110	10	255

¹ Contributions would be collected only during the last 6 months of 1966, and benefit payments would likewise be payable only during that period. Administrative expenses shown include both those for the full year 1966 and such expenses as incurred in 1965.

NOTE.—Not included above is the advance appropriation from general revenues that is to provide a contingency reserve during fiscal year 1966-67 (to be used only if needed and to be repayable).

6. IMPROVEMENT AND EXTENSION OF KERR-MILLS PROGRAM

(a) Background

The provision of medical care for the needy has long been a responsibility of the State and local public welfare agencies. In recent years, the Federal Government has assisted the States and localities in carrying this responsibility by participating in the cost of the care provided. Under the original Social Security Act, it was possible for the States, with Federal help, to furnish money to the needy with which they could buy the medical care they needed. Since 1950, the Social Security Act has authorized participation in the cost of medical care provided in behalf of the needy aged, blind, disabled, and dependent children—the so-called vendor payments. This method of providing care has proved popular with the suppliers of medical care, the agencies administering the programs, and the recipients themselves.

Several times since 1950, the Congress has liberalized the provisions of law under which the States administer the State-Federal program of medical assistance for the needy. The most significant enactment was in 1960 when the Kerr-Mills medical assistance for the aged program was authorized. This legislation offers generous Federal matching to enable the States to provide medical care in behalf of aged persons who

have enough income for their basic maintenance but not enough for medical care costs. This program has grown to the point where 40 States and 4 other jurisdictions have such a program and 227,000 aged were aided in December 1964. Furthermore, medical care as a part of the cash maintenance assistance programs has also grown through the years until, at this time, nearly all the States make vendor payments for some items of medical care for at least some of the needy.

Your committee bill is designed to liberalize the Federal law under which States operate their medical assistance programs so as to make medical services for the needy more generally available. To accomplish this objective, your committee bill would establish, effective January 1, 1966, a new title in the Social Security Act—"Title XIX: Grants to the States for Medical Assistance Programs." After an interim period ending June 30, 1967, all vendor payments for medical care, including medical assistance for the aged, would be administered under the provisions of the new title. Until June 30, 1967, States might continue operating under the vendor payment provisions of title I (old-age assistance and medical assistance for the aged), title IV (aid to families with dependent children), title X (aid to the blind), title XIV (aid to the permanently and totally disabled), and title XVI (the combined adult program), or if they wish, they might move as early as January 1, 1966, to the new title. Programs of vendor payments for medical care will continue, as now, to be optional with the States.

(b) State plan requirements

(1) Standard provisions

The provisions in the proposed title XIX contain a number of requirements for State plans which are either identical to the existing provisions of law or are merely conforming changes. These are:

That a plan shall be in effect in all political subdivisions of the State.

That there shall be provided an opportunity for a fair hearing for any individual whose claim for assistance is denied or not acted upon with reasonable promptness.

That the State agency will make such reports as the Secretary may from time to time require.

That there shall be safeguards provided which restrict the use or disclosure of information concerning applicants or recipients to purposes directly connected with the administration of the plan.

That all individuals wishing to make application for assistance under the plan shall have an opportunity to do so and that such assistance shall be furnished with reasonable promptness.

That in determining whether an individual is blind there shall be an examination by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select.

That medical assistance will be furnished to individuals who are residents of the State but who are absent therefrom.

(2) Additions to standard provisions

In addition to the requirements for State plans mentioned above, your committee bill contains several other plan requirements which are either new or changed over provisions currently in the law.

The bill provides that there shall be financial participation by the State equal to not less than 40 percent of the non-Federal share of the expenditures under the plan and that effective July 1, 1970, the financial participation by the State shall equal all the non-Federal share. This provision was included to make certain that the lack of availability of local funds for financing of any part of the program not affect the amount, scope, or duration of benefits or the level of administration set by the State. Prior to the 1970 date, your committee will be willing to consider other legislative alternatives to the provisions making the entire non-Federal share a responsibility of the State so long as these alternatives, in maintaining the concept of local participation, assure a consistent statewide program at a reasonable level of adequacy.

The bill contains a provision found in the other public assistance titles of the Social Security Act that the State plan must include such methods of administration as are found by the Secretary to be necessary for the proper and efficient operation of the plan, with the addition of the requirement that such methods must include provisions for utilization of professional medical personnel in the administration of the plan. It is important that State utilize a sufficient number of trained and qualified personnel in the administration of the program including both medical and other professional staff.

Your committee bill provides that the State or local agency administering the State plan under title XIX shall be the same agency which is currently administering either title I (old-age assistance) or that part of title XVI (assistance for the aged, blind, and the disabled, and medical assistance for the aged) relating to the aged. Where the program relating to the aged is State-supervised, the same State agency shall supervise the administration of title XIX. This provision was included because of the need to have the same agency which is most familiar with the administration of assistance (including medical care) to various groups of needy or nearly needy people also administer the medical assistance program. This is an agency with long experience and skill in determination of eligibility. Responsibility can be arranged by a welfare agency for actual provision of medical care by or through a health agency under suitable contractual relationships as some States have done under the MAA program.

Moreover, your committee recognizes that there are other State agencies with responsibilities for the provision of medical care or for various types of rehabilitative services in the States. In order to make certain that there is no duplication of effort and that maximum utilization will be made of the resources available from such other agencies, your committee bill provides that the State's plan must include provisions for entering into cooperative arrangements with State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services in the States.

Your committee bill also provides that if, on January 1, 1965, and on the date a State submits its title XIX plan, the State agency administering or supervising the administration of the State plan for the blind under title X or title XVI of the Social Security Act is different from the State agency administering or supervising the administration of the plan relating to the aged under title I or title XVI, such blind agency may be designated to administer or supervise the administration of the portion of the title XIX plan which relates to blind individ-

uals. In such case, the portion of the title XIX plan administered or supervised by each agency shall be regarded as a separate plan.

Current provisions of law requiring States to have an agency or agencies responsible for establishing and maintaining standards for the types of institutions included under the State plan have been continued under the bill. Your committee expects that these provisions will be used to bring about progressive improvement in the level of institutional care and services provided to recipients of medical assistance. Standards of care in many medical institutions are not now at a satisfactory level and it is expected that current standards applicable to medical institutions will be improved by the State's standard-setting agency and that these standards will be enforced by the appropriate State body.

Under provisions of your committee bill, the State plan must include such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and that such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipient. This provision was included in order to provide some assurance that the States will not use unduly complicated methods of determining eligibility which have the effect of delaying in an unwarranted fashion the decision on eligibility for medical assistance or that the States will not administer the provisions for services in a way which adversely affects the availability or the quality of the care to be provided. Your committee expects that under this provision, the States will be eliminating unrewarding and unproductive policies and methods of investigation and that they will develop such procedures as will assure the most effective working relationships with medical facilities, practitioners, and suppliers of care and service in order to encourage their full cooperation and participation in the provision of services under the State plan.

(c) Eligibility for medical assistance

Under your committee bill, a State plan to be approved must include provision for medical assistance for all individuals receiving aid or assistance under State plans approved under titles I, IV, X, XIV, and XVI. These people are the most needy in the country and it is appropriate for medical care costs to be met, first, for these people. Thus, under the provisions of the bill, these people will have the first call upon the resources of the States to provide medical care. It is only if this group is provided for that States may include medical assistance to the less needy than those who would be eligible for aid under the various other categories of public assistance.

Under your committee bill, medical assistance made available to persons receiving assistance under title I, IV, X, XIV, or XVI must not be less in amount, duration, or scope than that provided for persons receiving aid under any other of those titles. In other words, the amount, duration, and scope of medical assistance made available must be the same for all such persons. This will assure comparable treatment for all of the needy aided under the federally aided categories of assistance and will eliminate some of the unevenness which has been apparent in the treatment of the medical needs of various groups of the needy.

The bill provides furthermore that as States extend their programs to include assistance for persons who come within the various cate-

gories of assistance except that their income and resources are sufficient to meet their needs for maintenance, the medical assistance given such individuals shall not be greater in amount, duration, or scope than that made available for persons who are recipients of money payments. This was included in order to make sure that the most needy in a State receive no less comprehensive care than those who are not as needy.

Under the bill, if a State extends the program to those persons not receiving assistance under titles I, IV, X, XIV, and XVI, the determination of financial eligibility must be on a basis that is comparable as among the people who, except for their income and resources, would be recipients of money for maintenance under the other public assistance programs. Thus, the income and resources limitation for the aged must be comparable to that set for the disabled and blind and must also have a comparability for that set for families with children who, except for their income and resources, would be eligible for AFDC. The scope, amount, and duration of medical assistance available to each of these groups must be equal.

(d) Determination of need for medical assistance

Your committee bill would make more specific a provision now in the law that in determining eligibility for and the extent of aid under the plan, States must use reasonable standards consistent with the objectives of the titles. Although States may set a limitation on income and resources which individuals may hold and be eligible for aid, they must do so by maintaining a comparability among the various categorical groups of needy people. Whatever level of financial eligibility the State determines to be that which is applicable for the eligibility of the needy aged, for example, shall be comparable to that which the State sets to determine the eligibility for the needy blind and disabled; and must also have a comparability to the standards used to determine the eligibility of those who are to receive medical assistance as needy children and the parents or other relatives caring for them.

Another provision is included that requires States to take into account only such income and resources as (determined in accordance with standards prescribed by the Secretary) are actually available to the applicant or recipient and as would not be disregarded (or set aside for future needs) in determining the eligibility for and the amount of the aid or assistance in the form of money payments for any such applicant or recipient under the title of the Social Security Act most appropriately applicable to him. Income and resources taken into account, furthermore, must be reasonably evaluated by the States. These provisions are designed so that the States will not assume the availability of income which may not, in fact, be available or over-evaluate income and resources which are available. Examples of income assumed include support orders from absent fathers, which have not been paid or contributions from relatives which are not in reality received by the needy individual. The provisions also are designed to assure that whatever is applicable under titles I, IV, X, XIV, and XVI for the disregarding of income or for setting aside of income shall also be applicable in evaluating the income of the individual who is applying for medical assistance under title XIX. Titles I and X now provide for the disregarding of certain income and title IV provides

that income may be set aside for the future needs of the children. Other pertinent provisions for the disregard of income are found in the Economic Opportunity Act and the Food Stamp Act of 1964.

Your committee has heard of hardships on certain individuals by requiring them to provide support and to pay for the medical care needed by relatives. Your committee believes it is proper to expect spouses to support each other and parents to be held accountable for the support of their minor children and their blind or permanently and totally disabled children even though 21 years of age or older. Such requirements for support may reasonably include the payment by such relative, if able, for medical care. Beyond such degree of relationship, however, requirements imposed are often destructive and harmful to the relationships among members of the family group. Thus, States may not include in their plans provisions for requiring contributions from relatives other than a spouse or the parent of a minor child or children over 21 who are blind or permanently and totally disabled. Any contributions actually made by relatives or friends, or from other sources will be taken into account by the State in determining whether the individual applying for medical assistance is, in fact, in need of such assistance.

The bill also contains a provision designed to correct one of the weaknesses identified in the medical assistance for the aged program. Under the current provisions of Federal law, some States have enacted programs which contain a cutoff point on income which determines the financial eligibility of the individual. Thus, an individual with an income just under the specified limit may qualify for all of the aid provided under the State plan. Individuals, however, whose income exceeds the limitation adopted by the State are found ineligible for the medical assistance provided under the State plan even though the excess of the individual's income may be small when compared with the cost of the medical care needed. In order that all States shall be flexible in the consideration of an individual's income, your committee bill requires that the States standards for determining eligibility for and extent of medical assistance shall take into account, except to the extent prescribed by the Secretary, the cost—whether in the form of insurance premiums or otherwise—incurred for medical care or any other type of remedial care recognized under State law. Thus, before an individual is found ineligible for all or part of the cost of his medical needs, the State must be sure that the income of the individual has been measured in terms of both the State's allowance for basic maintenance needs and the cost of the medical care he requires.

The State may require the use of all the excess income of the individual toward his medical expenses, or some proportion of that amount. In no event, however, with respect to either this provision or that described below with reference to the use of deductibles for certain items of medical service, may a State require the use of income or resources which would bring the individual below the test of eligibility under the State plan. If the test of eligibility should be \$2,000 a year, an individual with income in excess of that amount shall not be required to use his income to the extent he has remaining less than \$2,000. This action would reduce the individual below the level determined by the State as necessary for his maintenance.

The bill contains several interrelated provisions which prohibit or limit the imposition of any deduction, cost sharing, or similiar charge,

nor of any enrollment fee, premium, or similar charge, under the plan.

No deduction, cost sharing or similar charge may be imposed with respect to inpatient hospital services furnished under the plan. This provision is related to another provision in the bill which requires States to pay reasonable costs for inpatient hospital services provided under the plan. Taken together, these provisions give assurance that the hospital bill incurred by a needy individual shall be paid in full under the provisions of the State plan for the number of days covered and that States may not expect or require the individual to use his income or resources (except such income as exceeds the State's maintenance level) toward that bill. The reasonable cost of inpatient hospital services shall be determined in accordance with standards approved by the Secretary and included in the State plan.

For any other items of medical assistance furnished under the plan, a charge of any kind may be imposed only if the State so chooses, and the charge must be reasonably related to the recipient's income or his income and resources. The same limitations apply in the case of any enrollment fee, premium, or similar charge imposed with respect to inpatient hospital services. The Secretary is given authority to issue standards under this provision, which it is expected will protect the income and resources an individual has which are necessary for his nonmedical needs.

The hospital insurance benefit program included under other provisions of the bill provides for a deductible which must be paid in connection with the individual's claim for hospitalization benefits. Your committee is concerned that hospitalization be readily available to needy persons and that the necessity of their paying deductibles shall not be a hardship on them or a factor which may prevent their receiving the hospitalization they need. For this reason, your committee's bill provides that the States make provisions, for individuals 65 years or older, of the cost of any deductible imposed with respect to individuals under the program established by the hospital insurance provisions of the bill.

A State medical assistance plan may provide for the payment in full of any deductibles or cost sharing under the insurance program established by part B of title XVIII. In the event, however, the State plan provides for the individual to assume a portion of such costs, such portion shall be determined on a basis reasonably related to the individual's income or income and resources and in conformity with standards issued by the Secretary. The Secretary is authorized to issue standards—under this provision which, it is expected, will protect the income and resources of the individual needed for his maintenance—to guide the States. Such standards shall protect the income and resources of the individual needed for his maintenance and provide assurance that the responsibility placed on individuals to share in the cost shall not be an undue burden on them.

Titles I and XVI authorizing the medical assistance for the aged program now provide that the States may not impose a lien against the property of any individual prior to his death on account of medical assistance payments except pursuant to a court judgment concerning incorrect payments, and prohibits adjustment or recovery for amounts correctly paid except from the estate of an aged person after his death and that of his surviving spouse. This provision, under your com-

mittee bill, has been broadened so that such an adjustment or recovery would be made only at a time when there is no surviving child who is under the age of 21 or who is blind or permanently and totally disabled.

(e) *Scope and definition of medical services*

"Medical assistance" is defined under the bill to mean payment of all or part of the care and services for individuals who would if needy, be dependent under title IV, except for section 406(a)(2), and are under the age of 21, or who are relatives specified in section 406(b)(1) with whom the child is living, or who are 65 years of age and older, blind, or permanently and totally disabled, but whose income and resources are insufficient to meet all their medical care costs. The bill, as do current provisions of law, permits Federal sharing in the cost of medical care provided up to 3 months before the month in which the individual makes application for assistance. Thus, the scope of the program includes not only the aged, blind, disabled, and dependent children as defined in State plans, but also children under the age of 21 (and their caretaker relatives) who come within the scope of title IV, except for need and age, even though they may not be defined as eligible under a particular State plan.

Your committee bill contains a list of services, the first five of which the States are required to include in their plans, if they elect to implement title XIX, and the remainder of which are optional with the States. The required services are:

- Inpatient hospital services.
- Outpatient hospital services.
- Other laboratory and X-ray services.
- Skilled nursing home services.

Physicians' services, whether furnished in the office, the patient's home, a hospital, or a skilled nursing home or elsewhere.

In the opinion of your committee, these are the most essential items of service which should be included as a minimum if the medical assistance program is to be of significant help to the individual. These minimum items of service are to become effective July 1, 1967; until then, the State plan must include—as now provided in titles I and XVI—for some institutional and some noninstitutional services.

Other items of medical service which the States may, if they wish include in their plans are:

Medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

Home health care services.

Clinic service.

Private duty nursing service.

Dental service.

Physical therapy and related services.

Prescribed drugs, dentures, prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select.

Other diagnostic, screening, preventive, and rehabilitative services.

Any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary.

The States must pay the reasonable cost of inpatient hospital services for the number of days of care provided under the plan.

Among the items of medical services which the States may include is medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. Under this provision, a State may if it wishes, include medical and remedial services provided by osteopaths, chiropractors, optometrists and podiatrists, and Christian Science practitioners, if such practitioners and services are licensed by the State.

If a State chooses to provide eyeglasses as a service under the plan, your committee believes that the individual recipient should be free to select either a physician skilled in diseases of the eye or an optometrist to provide these glasses. Many small communities do not have qualified ophthalmologists but do have optometrists who are competent to provide, fit, or change eyeglasses.

In addition to the items specifically listed, the Secretary is authorized to define any other medical care or any other type of remedial care recognized under State law which he believes might be provided by the States and in which the Federal Government will participate financially.

The State plan may not include any individual who is an inmate of a public institution, except as a patient in a medical institution; nor may it include any individual under the age of 65 who is a patient in an institution for tuberculosis or mental diseases.

Under title XIX, it will be possible for States to give medical assistance to persons 65 years of age and older who are in mental and tuberculosis institutions and to otherwise eligible persons of any age with a diagnosis of psychosis or tuberculosis and who are receiving care in other medical institutions. Under the bill, if the plan includes medical assistance for patients in institutions for mental diseases or tuberculosis, various requirements are specified for inclusion in the State plan with respect to these individuals and various other fiscal and other provisions are included. These are identical with those included in title II, part 3 of the bill and are explained elsewhere in this report.

Medical assistance provided under the bill may include payment for care and services provided at any time within the month in which an individual becomes eligible or ineligible for assistance, e.g., by attaining a specified age. This avoids the administrative inconvenience of having to segregate bills by the day of the month on which care or services were provided and is consistent with the monthly pattern of benefits under the other public assistance titles.

(f) Other conditions for plan approval

Title XIX requires that the Secretary approve any plan which fulfills the plan requirements specified and described above and which does not contain certain other conditions. Under these provisions, a State plan may not include an age requirement of more than 65 years. Effective July 1, 1967, States may not, under the provisions of your committee bill, exclude any individual who has not attained the age of 21 and is, or would, except for the provisions of section 406(a)(2) be a dependent child under title IV. Thus, States will include within the scope of their plan all children

under the age of 21—whether or not they are attending school or taking a program of vocational training—who would otherwise be within the scope of eligibility of a dependent child as defined under title IV of the Social Security Act. This provision was included in order to provide assurance that children under the age of 21 will have their medical needs met if they are either a member of a family receiving a money payment under title IV of the Social Security Act or a member of a family which has the need and other characteristics described under title IV.

The Secretary would be prohibited from approving any plan which imposed a residence or citizenship requirement that goes beyond those now in title I and title XVI as they relate to the medical assistance for the aged program. In addition, the Secretary is directed not to approve any State plan for medical assistance if he finds that the approval and operation of the plan will result in a reduction in the level of aid or assistance provided for eligible individuals under title I, IV, X, XIV, or XVI. An exception is provided allowing States to reduce such aid to the extent that assistance now provided under titles I, IV, IX, XIV, and XVI is to be provided under title XIX. The reason your committee recommends the inclusion of this provision is to make certain that States do not divert funds from the provision of basic maintenance to the provision of medical care. If the Secretary should find that his approval of a title XIX plan would result in a reduction of aid or assistance for persons receiving basic maintenance under the public assistance titles of the Social Security Act (except as specified above) he may not approve such a plan under title XIX. Your committee recognizes the need and urgency for States to maintain, if not improve, the level of basic maintenance provided for needy people under the public assistance programs. The provision is intended to prevent any unwarranted diversion of funds from basic maintenance to medical care.

(g) Financing of medical assistance

Your committee bill provides for payments under title XIX, beginning with the quarter commencing January 1, 1966. States with approved plans would receive an amount equal to the Federal medical assistance percentage of the total amount expended during a quarter as medical assistance under the State plan. This percentage is described below. The amount expended as medical assistance for purposes of Federal matching include expenditures for premiums under part B of title XVIII for individuals who are recipients of money payments under one of the Federal-State public assistance programs. This may include payment of premiums for those individuals covered under agreements between the State and the Secretary, and also for other money payment recipients who are eligible under part B of title XVIII. In addition, expenditures for other insurance premiums for medical or any other type of remedial care or the cost thereof are matchable as medical assistance. (The definitions of assistance in the public assistance titles of the Social Security Act would also be amended to include similar provisions.)

In addition, the States are to receive 75 percent of so much of the sums expended during the quarter as found necessary by the Secretary for the proper and efficient administration of the State plan as are attributable to the compensation of skilled professional medical person-

nel and staff directly supporting such personnel of the State agency or the local agency administering the plan in the political subdivision. This provision was included in order to provide adequate Federal financial support for the staffing of the State and local public welfare departments by such skilled professional medical personnel and staff directly supporting such personnel as may be necessary. Such staff will include physicians, medical administrators, medical social work personnel, and other specialized personnel necessary to assure an adequate number of persons to do a quality job as well as the clerical staff, directly associated with the professional staff, and the necessary travel and other closely related expenditures. It is very likely that some people in need of medical assistance will need related social services in order to receive the full benefits of the program. Under the 1962 public welfare amendments, States may receive 75 percent Federal sharing in the cost of services provided to persons receiving aid under titles I, IV, X, XIV, and XVI to former recipients of assistance under these titles and persons likely to become recipients of aid under these titles. Thus adequate provisions are already available to help the States finance the provision of social services to those receiving medical assistance or the cost of training staff to provide such services and no such provision is included in the new title.

In addition, the States are to receive one-half of all other expenditures found by the Secretary to be necessary for the proper and efficient administration of the State plan.

The Federal medical assistance percentage is determined in accordance with a formula described in the bill. It provides that a State whose per capita income is equal to the national average per capita income shall receive 55 percent Federal matching. States whose per capita income is below the national average shall receive correspondingly higher proportions of Federal funds up to a maximum of 83 percent. States whose per capita income is above the national average shall receive correspondingly lower percentages but not less than 50 percent. The medical assistance percentages for Puerto Rico, the Virgin Islands, and Guam shall be 55 percent. The method of determining the Federal medical assistance percentage and the frequency of its determination and promulgation are (after the initial promulgation for the period January 1, 1966, to June 30, 1967) already specified in the law.

There is a special provision for adjustment of the Federal medical assistance percentage for any State which might not otherwise receive full advantage from the title XIX formula. It is provided that during the period from January 1, 1966, through June 30, 1969, the Federal medical assistance percentage under title XIX for any State shall not be less than 105 percent of the Federal share of medical expenditures by the State during fiscal year 1965. The computation is made by determining the amount of Federal payments made to each State for fiscal year 1965 under all of the public assistance titles, which would not have been payable except for the making of vendor medical payments. This amount of Federal payments is compared with the total amount of vendor medical expenditures under the public assistance plans (whether below or above the matching ceilings under the Federal statutory formulas) to give the Federal share of medical expenditures by the State during fiscal year 1965. The raising of the

Federal medical assistance percentage to 105 percent of the Federal share of medical expenditures for 1965 will obviate certain inequities in the various formulas and will enable a few States which might not otherwise do so to receive some additional Federal funds as an incentive for an improved program.

Provisions relating to the availability of Federal sharing in the cost of medical assistance for persons 65 years of age or older who are patients in mental or tuberculosis hospitals specify that the States will receive additional Federal funds only to the extent that a showing is made to the satisfaction of the Secretary that the additional funds being received are being used to extend and improve the mental health program of the States. Comparable provisions appear in title II, part 3 of the bill, and are explained more fully in that part of this report relating to title II.

The provisions of title IV, section 405 of the bill, described elsewhere in this report are designed to assure that the additional Federal funds which are to accrue to the States under the operation of the formula described above, shall be used directly in the public assistance program and may not be withdrawn from the program by the States.

The bill sets forth provisions comparable to those which are in other of the public assistance titles of the Social Security Act describing the procedure by which the State submits its estimates of the funds it will need and receives payments under its approved plan, and the procedures to be followed in the event it should become necessary to question the continued receipt of Federal funds under the new title. There is also a new provision limiting payments made under the new title to States making a satisfactory showing of efforts toward broadening the scope of care and services made available under the plan. This showing must be such that the Secretary is reasonably convinced the program of medical assistance will have such liberalized eligibility requirements and comprehensive care and services, including needed social services to achieve independence or self-care that by July 1, 1975, assistance and services needed will be available to substantially all individuals who meet the State's eligibility standards with respect to income and resources. This provision was included in order to encourage the continued development in the States of a broadened and more liberalized medical assistance program so that all persons who meet the State's test of need, whose own resources, and the resources available to them under other programs for medical care, including those established for Federal matching under this bill, are insufficient, will receive the medical care which they need by 1975.

(h) Miscellaneous provisions

Title XIX would under the provisions of your committee bill become effective January 1, 1966. No payments may be made to a State under title I, IV, X, XIV, or XVI with respect to aid or assistance in the form of medical or other types of remedial care for any period for which such State receives payment under title XIX or for any period after June 30, 1967. Thus, under the provisions of your committee bill, a State is permitted to implement title XIX at any time it wishes commencing January 1, 1966, but must do so by July 1, 1967, if it wishes to receive Federal participation in vendor payments for medical care. When a title XIX plan has gone into effect pursuant to the bill, all vendor medical payments made on or after the effective date

(and administrative costs on or after the effective date, which are related to vendor medical payments) will be accounted for under title XIX, and not under the other titles.

The bill also makes technical and conforming amendments.

(i) *Cost of medical assistance*

As the accompanying table shows, if all States took full advantage of provisions of the proposed title XIX, the additional Federal participation would amount to \$238 million. However, because all States cannot be expected to act immediately to establish programs under the new title and because of provisions in the bill which permit States to receive the additional funds only to the extent that they increase their total expenditures, the Department of Health, Education, and Welfare estimates that additional Federal costs in the first year of operation will not exceed \$200 million. Since the new title would be effective only for the last 6 months of the fiscal year ending June 30, 1966, expenditures in that fiscal year are not expected to exceed \$100 million.

Public assistance: Increased Federal funds available for medical payments under title XIX¹

[In thousands of dollars]

State	Increase available under title XIX ¹	State	Increase available under title XIX ¹
Total.....	\$238,005	Missouri.....	350
Alabama.....	1,045	Montana.....	27
Alaska.....	5	Nebraska.....	1,511
Arizona.....	19	Nevada.....	263
Arkansas.....	3,905	New Hampshire.....	1,931
California.....	20,411	New Jersey.....	5,559
Colorado.....	2,689	New Mexico.....	1,634
Connecticut.....	3,922	New York.....	46,580
Delaware.....	8	North Carolina.....	2,890
District of Columbia.....	344	North Dakota.....	3,809
Florida.....	684	Ohio.....	2,871
Georgia.....	363	Oklahoma.....	14,752
Hawaii.....	898	Oregon.....	1,291
Idaho.....	477	Pennsylvania.....	3,038
Illinois.....	18,395	Rhode Island.....	2,437
Indiana.....	2,136	South Carolina.....	2,133
Iowa.....	5,315	South Dakota.....	148
Kansas.....	5,808	Tennessee.....	324
Kentucky.....	262	Texas.....	1,247
Louisiana.....	3,950	Utah.....	3,028
Maine.....	781	Vermont.....	530
Maryland.....	141	Virginia.....	159
Massachusetts.....	16,614	Washington.....	2,290
Michigan.....	3,715	West Virginia.....	2,260
Minnesota.....	27,578	Wisconsin.....	17,031
Mississippi.....	317	Wyoming.....	280

¹ Based on expenditures for vendor medical payments from State and local funds for all programs combined in January 1964. If State and local expenditures were reduced, the Federal expenditure would be correspondingly lower, while increases in State and local expenditures would also result in increases in the Federal cost.

B. CHILD HEALTH AMENDMENTS

1. SUMMARY OF COMMITTEE ACTION

Your committee believes that the proposals embodied in part 1, title II of its bill will help to improve the health care of many low-income preschool and school age children and youth.

Your committee's bill would—

(1) Increasing the amounts authorized for maternal and child health services and crippled children's services under title V of the Social Security Act in order to assist the States to move toward the goal of extending such services with a view to making them reasonably available to children in all parts of the State by July 1, 1975;

(2) Authorizing grants for the training of personnel to serve crippled children, particularly mentally retarded children and children with multiple handicaps, and;

(3) Authorizing a new 5-year program of special project grants to provide comprehensive health care and services for children of school age and for preschool children.

(a) *Maternal and child health services*

The amount of Federal funds going into maternal and child health services in the fiscal year 1964 was approximately \$28 million. State and local funds were more than three times as much, about \$92 million.

States use Federal funds, together with State and local funds, to pay the costs of conducting prenatal clinics where mothers are examined by physicians and get medical advice; for visits by public health nurses to homes before and after babies are born to help mothers care for their babies; for well-child clinics where mothers can bring their babies and young children for examination and immunizations, where they can get competent advice on how to prevent illnesses and where their many questions about the care of babies can be answered. Such measures have been instrumental in the reduction of maternal and infant mortality, especially in rural areas. Funds are used to make available doctors, dentists, and nurses to the schools for health examinations of schoolchildren. They are also used for immunizations. These funds support diagnostic, treatment and counseling services for mentally retarded children in 47 States. Practically all States use some of the funds for improving the quality of services to mothers and children by providing special training opportunities to physicians, nurses, nutritionists, medical social workers, and other professional personnel. In addition, States carry out demonstration programs of various kinds.

Your committee believes that increases in the child population and the cost of medical care, wide variations among the States in maternal and infant mortality, and the uneven distribution of basic health services indicate the need for additional Federal support in order to help States make their maternal and child health services available to children in all parts of the State by July 1, 1975.

Existing ceilings on authorizations for appropriations for maternal and child health services are:

\$40 million each for the fiscal years ending June 30, 1966, and 1967;

\$45 million each for the fiscal years ending June 30, 1968, and 1969; and

\$50 million for the fiscal year ending June 30, 1970, and for each fiscal year thereafter.

Your committee's bill would authorize an increase in these ceilings on appropriations to:

\$45 million for the fiscal year ending June 30, 1966;

\$50 million for the fiscal year ending June 30, 1967;

\$55 million each for the fiscal years ending June 30, 1968, and 1969; and

\$60 million for the fiscal year ending June 30, 1970, and for succeeding fiscal years.

Such increases are authorized in order to help extend maternal and child health services to additional parts of the States, thus providing preventive health services for more mothers and children and contributing to further reduction of infant mortality through greater availability of services.

(b) Crippled children's services

About \$29 million of Federal funds was expended for services for crippled children in fiscal year 1964. Expenditures from State and local funds were more than twice as much—nearly \$60 million.

The program now includes children for whom medical or surgical care formerly was not available or feasible. Under the committee's bill, all State crippled children's agencies could make their services increasingly available to children with all kinds of handicaps such as cystic fibrosis, congenital heart disease, neurological disorders, epilepsy, hemophilia, and other problems. Some States have programs for the diagnosis, treatment, and aftercare of children with multiple handicaps, most of whom have varying degrees of mental retardation.

In 1963 about 400,000 children under 21 years of age received physicians' services under the crippled children's programs. Approximately 293,000 children attended diagnostic clinics and close to 70,000 children received hospitalization. About 35 percent of expenditures in the crippled children's program are for hospital care.

One-half of the children diagnosed in 1963 were children with non-orthopedic defects. Deformities of a congenital nature were the largest single group of primary conditions among children served, nearly 30 percent of all children served. Roughly 20 percent of these congenital conditions consisted of malformations of the heart and circulatory system.

However, differences in rate of service among States is considerable, the highest being 165 per 10,000, the lowest 15. This unevenness is indicative of the need for considerable growth of these programs in many States. Many crippled children or children with potentially crippling conditions do not receive needed care because their conditions may not be included in the State's program. For example, a number of States do not include children with epilepsy; others do not include children with strabismus, neglect of which often results in loss of vision in the affected eye; some States do not include children with hearing impairments. The major reason for these deficiencies in State programs is inadequate funds.

Existing authorizations for crippled children's services are:

\$40 million each for the fiscal years ending June 30, 1966, and 1967;

\$45 million each for the fiscal years ending June 30, 1968, and 1969; and

\$50 million for the fiscal year ending June 30, 1970, and for each fiscal year thereafter.

Your committee's bill would authorize an increase in the ceiling on appropriations to:

- \$45 million for the fiscal year ending June 30, 1966;
- \$50 million for the fiscal year ending June 30, 1967;
- \$55 million each for the fiscal years ending June 30, 1968, and 1969; and
- \$60 million for the fiscal year ending June 30, 1970, and for succeeding fiscal years.

Such increases would assist the States to move toward the goal of extending crippled children's services with a view to making such services available to children in all parts of the State by July 1, 1975.

Extension of services for crippled children to areas of a State not now served will increase the number of children helped by the program, and make services more accessible in all parts of a State. The increased funds will also help States to extend their programs and further broaden their definitions of "crippling."

(c) Training of professional personnel for the care of crippled children

Your committee's bill would authorize a program of grants to institutions of higher learning for training (and related costs) of professional personnel such as physicians, psychologists, nurses, dentists, and social workers for work with crippled children and particularly mentally retarded children and those with multiple handicaps. Authorizations would be \$5 million for the fiscal year ending June 30, 1967, \$10 million for the fiscal year ending June 30, 1968, and \$17.5 million for each fiscal year thereafter.

Of the 4.1 million children born each year about 3 percent—at birth or later—will be classified as mentally retarded. The 27,000 children in 1963 who were served by the 92 clinics in the country supported with maternal and child health and crippled children's funds represent only a small fraction of the children who need this kind of help. A large number of these children also have physical handicaps. Despite the growth in the number of clinics serving mentally retarded children, and the increase in the number of children served, waiting lists remain long. Lack of sufficient numbers of trained personnel to staff clinics is a major reason why applications for services for mentally retarded children exceed existing resources.

The growth of programs for children with various handicapping conditions including those who are mentally retarded and the construction of new university centers for clinical services and training are increasing the demands for adequate trained professional personnel. These centers will offer a complete range of services for the mentally retarded and will demonstrate programs of specialized services for the diagnosis, treatment, education, training, and care of mentally retarded children, including retarded children with physical handicaps. They will be resources for the clinical training of physicians and other specialized personnel needed for research, diagnosis, training, or care.

The program would help to reduce the severe shortage of professional personnel to serve mentally retarded children and children with multiple handicaps. The training of health personnel authorized is

not intended to, and in your committee's judgment will not, in any way duplicate other programs of training (such as those for teachers) of personnel to work with the mentally retarded.

(d) Payment for inpatient hospital services

The bill also provides for payment of the reasonable cost of inpatient hospital services provided under the State plans for maternal and child health services and crippled children's services. Reasonable costs are to be determined in accordance with standards approved by the Secretary.

(e) Special project grants for low-income school and preschool children.

The bill would authorize a 5-year program of special project grants to provide comprehensive health care and services for children of school age, or for preschool children, particularly in areas with concentrations of low-income families. Projects would provide screening, diagnosis, preventive services, treatment, correction of defects, and aftercare for children in low-income families.

Your committee has evidence that many of the health needs of preschool children and children of school age, particularly children from low-income families, are not being met because of the increase in the child population. This is resulting in great crowding of clinics available to low-income families and inadequate preventive health services and medical care for their children.

The maternal mortality rate in 1961-62 in low-per-capita income States was 57 percent higher than in high-per-capita income States, 50 maternal deaths per 100,000 live births as compared with 31.9.

The infant mortality rate for low-income States in 1962, 29.6 per 1,000 live births, was 17 percent above that prevailing in high-income States.

Hospitalization rates for children coming from families whose income was under \$2,000 were at the rate of 42.4 per 1,000 whereas children from families with incomes of \$7,000 and over were hospitalized at the rate of 67.7 per 1,000.

The average length of hospital stay for all children under 15 was 6 days. For children whose family income was under \$2,000 the average hospital stay was 9.3 days contrasted with 4.8 days for children coming from families with an income of \$7,000 and over.

School aged children 5 to 17 numbered 44 million in 1960 and may reach 54 million by 1970; an increase of about 24 percent. The 4,250,000 children born in 1960 will be enrolled in school in 1966. Much can be done to help preschool children to get ready for school by correcting and preventing health handicaps.

Your committee is convinced that health supervision in the preschool years is important because many childhood disabling illnesses both physical and emotional have their origin in infancy or the preschool years. Effective health supervision for children during the years before entering school would help considerably to get them ready for school and reduce the extent of the need for school health services for

children in the first year of school. Such care should also be extended through adolescence.

In school health programs, the availability of community resources to which children can be referred for diagnosis and treatment is the critical factor in the essential followup services. Without such resources, school health services have little meaning for low-income families. Communities are finding that they do not have adequate resources to which children can be referred for diagnosis and treatment when they are found to be in need of treatment through school health programs and their resources for the examination, diagnosis, and treatment of preschool children to help them prepare to enter school are also too few and too crowded.

Large numbers of our children enter school and spend their school-days with conditions which interfere with their growth, development, and education:

About 10,200,000 schoolchildren are in need of eye care;

About 1,500,000 children have hearing impairments—about 7 percent already have hearing loss when they enter school;

One in five children under age 17 has a chronic ailment;

Four million children are emotionally disturbed;

Half the children under 15 years in the United States have never been to a dentist and the proportion is much greater in families with incomes under \$2,000;

Children in families with incomes of less than \$2,000 visit the doctor only half as frequently as those in families with incomes of more than \$7,000;

Your committee's proposal will make possible programs organized to make maximum use of available community medical services and to bring about a better distribution of the low-income patient group among public and voluntary community clinics and hospitals.

To be eligible for a grant a project must provide for—

(1) Coordination with and utilization of other State and local health, welfare, and education programs for such children;

(2) Payment of reasonable cost of in-patient hospital services;

(3) Treatment, correction of defects or after care to be available only to children who would not otherwise receive it because they are from low-income families or for other reasons beyond their control; and

(4) Inclusion of such screening, diagnosis, preventive services, treatment, correction of defects, and after care, medical or dental, as required by the Secretary.

Authorizations for appropriations would be:

\$15 million for the fiscal year ending June 30, 1966;

\$35 million for the fiscal year ending June 30, 1967;

\$40 million for the fiscal year ending June 30, 1968;

\$45 million for the fiscal year ending June 30, 1969, and \$50 million for the fiscal year ending June 30, 1970.

A full report with evaluation and recommendations is to be submitted to the President for transmission to the Congress before July 1, 1969.

The grants would be available to the State health agency or with its consent to the health agency of any political subdivision of the State, to the State agency administering or supervising the crippled children's program, to schools of medicine (with appropriate participation by schools of dentistry) and to teaching hospitals affiliated with schools of medicine.

The grants would pay not to exceed 75 percent of the cost of projects. Your committee recognizes, however, that non-Federal funds may have to be derived from a variety of sources, particularly at the beginning of the program. These might include existing funds and activities of the grantee agency; funds, equipment, time of personnel, or space made available by other agencies; or similar items or gifts from other sources.

Your committee is aware that other committees of the Congress have before them legislative proposals dealing with school and preschool children. Your committee has studied these proposals carefully and is thoroughly satisfied that there is no duplication of the services provided in the special project health grants for school and preschool children incorporated in the proposed new section 532 of title V of the Social Security Act and no duplication is intended. Furthermore, the Appropriations Committee will have an opportunity to look at these programs at the same time and evaluate their interrelationships.

This program would enable State or local health agencies, crippled children's agencies, and medical schools and teaching hospitals to provide comprehensive health care including dental care to children in need of such care in areas where low-income families are concentrated and to improve the amount and quality of care available to children of low-income families by the organization of the necessary services to provide care. It would reduce the numbers of children of preschool and school age who are hampered by remediable handicaps and provide necessary medical and dental care for children of low-income families who would otherwise not receive care.

2. COSTS OF IMPROVEMENTS IN MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S PROGRAMS

The accompanying tables indicate by State the allotments that would be made under the maternal and child health and crippled children's programs under the existing authorization of \$40 million for each of these programs for the fiscal year ending June 30, 1966, and the State allotments which would be made under the proposed authorization of \$45 million. The differences by State shown in the tables reflect the amount of additional funds that States would receive under the provisions of the bill in fiscal year ending June 30, 1966. Differences for subsequent years would be approximately twice as large.

The total additional authorizations for the four types of grant authorized under title II, part 1, amount to \$25 million additional Federal funds in the fiscal year ending June 30, 1966, and to approximately \$60 million for the first full year of operation.

Grant-in-aid apportionments in maternal and child health program comparison of \$45,000,000 appropriations with \$40,000,000 appropriations¹

State	Maternal and child health		
	\$40,000,000	\$45,000,000	Difference
United States.....	\$31,437,500	\$34,875,000	\$3,437,500
Alabama.....	779,483	865,734	86,251
Alaska.....	149,804	159,397	9,593
Arizona.....	264,259	292,373	28,114
Arkansas.....	461,030	511,649	50,619
California.....	1,762,722	1,961,629	198,907
Colorado.....	286,293	317,624	31,331
Connecticut.....	340,077	378,997	38,920
Delaware.....	164,678	176,565	11,887
District of Columbia.....	198,589	215,702	17,113
Florida.....	1,032,535	1,147,248	114,713
Georgia.....	985,295	1,094,585	109,290
Guam.....	130,061	136,612	6,551
Hawaii.....	189,032	204,672	15,640
Idaho.....	178,101	192,056	13,955
Illinois.....	993,623	1,133,275	139,652
Indiana.....	755,822	839,872	84,050
Iowa.....	477,111	529,723	52,612
Kansas.....	345,657	383,593	37,936
Kentucky.....	737,641	819,161	81,520
Louisiana.....	824,480	915,823	91,343
Maine.....	242,840	269,101	26,261
Maryland.....	626,668	696,062	69,394
Massachusetts.....	589,978	652,442	62,464
Michigan.....	1,190,820	1,323,871	133,051
Minnesota.....	603,346	670,198	66,852
Mississippi.....	719,492	798,867	79,375
Missouri.....	603,268	670,248	66,980
Montana.....	181,665	196,169	14,504
Nebraska.....	258,374	286,494	28,120
Nevada.....	156,861	167,542	10,681
New Hampshire.....	174,243	187,603	13,360
New Jersey.....	635,288	719,709	84,421
New Mexico.....	243,571	269,990	26,419
New York.....	1,653,908	1,840,461	186,553
North Carolina.....	1,208,705	1,342,775	134,070
North Dakota.....	179,079	193,185	14,106
Ohio.....	1,412,888	1,570,915	158,027
Oklahoma.....	392,553	435,721	43,168
Oregon.....	304,995	338,293	33,298
Pennsylvania.....	1,516,164	1,685,715	169,551
Puerto Rico.....	972,363	1,079,920	107,557
Rhode Island.....	190,794	206,706	15,912
South Carolina.....	725,666	805,734	80,068
South Dakota.....	185,011	200,031	15,020
Tennessee.....	790,909	878,471	87,562
Texas.....	1,547,537	1,720,787	173,250
Utah.....	216,786	236,704	19,918
Vermont.....	154,081	164,334	10,253
Virgin Islands.....	125,337	131,160	5,823
Virginia.....	904,121	1,004,415	100,294
Washington.....	474,460	525,821	52,361
West Virginia.....	397,854	441,417	43,563
Wisconsin.....	655,027	727,738	72,711
Wyoming.....	149,555	159,111	9,556

¹ Under sec. 502(a) (fund A), from a total of \$20,000,000, which is half of the appropriation, each State receives a uniform grant of \$70,000 and an additional grant in proportion to the number of live births in the State. Under sec. 502(b) (fund B), from the other \$20,000,000, \$4,750,000 is to be used only for special projects for mentally retarded children, and \$3,812,500 or 25 percent of the remaining \$15,250,000 is reserved for other special projects. The remainder, \$11,437,500, is apportioned so that each State receives an amount which varies directly with the number of urban and rural live births in the State and inversely with State per capita income. No State receives less than \$50,000. Live births in rural areas are given twice the weight of those in urban areas.

Grants-in-aid apportionments in crippled children's program comparison of \$45,000,000 appropriations with \$40,000,000 appropriations¹

State	Crippled children		
	\$40,000,000	\$45,000,000	Difference
United States	\$32,187,500	\$35,625,000	\$3,437,500
Alabama.....	863,999	952,425	88,426
Alaska.....	143,592	152,228	8,636
Arizona.....	281,235	310,553	29,318
Arkansas.....	531,492	585,446	53,955
California.....	1,590,273	1,821,887	231,614
Colorado.....	289,808	320,323	30,515
Connecticut.....	339,915	378,811	38,896
Delaware.....	162,260	173,773	11,513
District of Columbia.....	178,877	192,951	14,074
Florida.....	895,936	989,710	93,774
Georgia.....	1,024,979	1,130,223	105,244
Guam.....	127,529	133,689	6,160
Hawaii.....	183,185	197,923	14,738
Idaho.....	182,774	198,310	15,536
Illinois.....	990,813	1,101,414	110,601
Indiana.....	827,619	914,137	86,518
Iowa.....	549,886	606,602	56,716
Kansas.....	391,905	432,560	40,655
Kentucky.....	819,461	903,031	83,570
Louisiana.....	810,210	893,668	83,458
Maine.....	223,163	245,868	22,705
Maryland.....	455,442	504,001	48,559
Massachusetts.....	538,290	607,782	69,492
Michigan.....	1,201,634	1,326,113	124,479
Minnesota.....	654,333	722,413	68,080
Mississippi.....	764,518	841,932	77,414
Missouri.....	656,958	725,952	68,994
Montana.....	182,364	196,976	14,612
Nebraska.....	284,935	314,266	29,331
Nevada.....	154,259	164,546	10,287
New Hampshire.....	172,927	186,085	13,158
New Jersey.....	641,273	726,617	85,344
New Mexico.....	236,033	260,262	24,229
New York.....	1,474,981	1,683,826	213,845
North Carolina.....	1,332,455	1,468,283	135,828
North Dakota.....	183,254	201,706	18,452
Ohio.....	1,455,230	1,609,561	154,331
Oklahoma.....	463,581	511,446	47,865
Oregon.....	315,483	348,245	32,762
Pennsylvania.....	1,608,841	1,778,823	169,982
Puerto Rico.....	964,873	1,062,703	97,830
Rhode Island.....	189,749	205,500	15,751
South Carolina.....	775,982	854,813	78,831
South Dakota.....	192,665	212,111	19,446
Tennessee.....	894,080	955,655	61,575
Texas.....	1,721,357	1,902,532	181,175
Utah.....	217,034	236,986	19,952
Vermont.....	154,669	165,013	10,344
Virgin Islands.....	123,980	129,593	5,613
Virginia.....	928,948	1,024,700	95,752
Washington.....	485,437	536,208	50,769
West Virginia.....	482,236	531,184	48,948
Wisconsin.....	720,633	795,856	75,223
Wyoming.....	150,156	159,804	9,648

¹ Under sec. 512(a) (fund A) each State receives a uniform grant of \$70,000 and an additional grant in proportion to the number of children under 21 years in the State. Under sec. 512(b) (fund B) \$3,750,000 is to be used only for special projects for services for crippled children who are mentally retarded, and \$4,062,500 or 25 percent of the remaining \$16,250,000 is reserved for other special projects. The remainder, \$12,187,500, is apportioned so that each State receives an amount which varies directly with the number of children under 21 years in urban and rural areas in the State and varies inversely with State per capita income. No State receives less than \$50,000. Children in rural areas are given twice the weight of those in urban areas.

C. IMPLEMENTATION OF MENTAL RETARDATION PLANNING

Under the Maternal and Child Health and Mental Retardation Planning Amendments of 1963 (Public Law 88-156), \$2.2 million was authorized to provide small grants to States for the purpose of planning comprehensive programs in the field of mental retardation. The requirements for receipt of such grants included the involvement of all types of agencies—health, education, welfare, institutions, etc.—concerned with problems of the mentally retarded. Your committee is advised that each State has submitted an application and received a grant under this program.

In order to assure that the planning which is being done has impact on State programs, your committee believes that further limited grants for purposes of followup and implementation are warranted. The bill accordingly authorizes appropriations of \$2,750,000 each for the fiscal years ending June 30, 1966, and June 30, 1967, for this purpose. Each of these appropriations would be available for expenditure for the fiscal year for which it was made and for succeeding fiscal years that end prior to July 1, 1968.

D. GENERAL DISCUSSION OF OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE PROVISIONS

(1) SEVEN-PERCENT INCREASE IN BENEFITS

Your committee believes that a benefit increase at this time is obvious. For the overwhelming majority of the 20 million people now getting social security checks—aged and disabled people and their families and orphaned children and their widowed mothers—the benefits are the major source of support; for a great many they are the only source. The last general benefit increase was enacted in 1958 and was effective with benefits payable for January 1959. Since that date there have been changes in wages, prices, and other aspects of the economy. For the aged, who generally are the most economically disadvantaged group, the combined effect of the 7-percent increase and the hospital insurance benefits will be to provide a substantial improvement in levels of living.

Under the bill monthly benefits for retired workers now on the benefit rolls who began to draw benefits at age 65 or later would range from \$44 to \$135.90, as compared with \$40 to \$127 under present law. Because of the increases that the bill would make in the contribution and benefit base, retired workers coming on the rolls in the future with benefits based on average monthly earnings of more than \$400, the highest possible under present law, would of course get benefits of more than \$135.90. The increases in the base, together with the benefit increase, would result in a maximum benefit for the worker of \$149.90, payable on average monthly earnings of \$466 (the highest possible under the \$5,600 contribution and benefit base), and ultimately in a maximum benefit of \$167.90, payable on the average monthly earnings of \$550 that are possible under the \$6,600 contribution and benefit base. The following table is illustrative of benefit amounts for various family groups under the \$5,600 contribution and benefit base and under present law.

Illustrative monthly benefits payable under present law and under the committee bill with a \$5,600 contribution and benefit base¹

Average monthly earnings	Old-age benefits ²				Survivors benefits			
	Worker		Man and wife ³		Widow aged 62, widower, or parent		Widow and 2 children	
	Present law	Bill	Present law	Bill	Present law	Bill	Present law	Bill ⁴
\$67 or less.....	\$40	\$44.00	\$60.00	\$66.00	\$40.00	\$44.00	\$60.00	\$66.00
\$100.....	59	63.20	88.50	94.80	48.70	52.20	88.50	94.80
\$150.....	73	78.20	109.50	117.30	60.30	64.60	120.00	120.00
\$200.....	84	89.90	126.00	134.90	69.30	74.20	161.70	161.70
\$250.....	95	101.70	142.50	152.60	78.40	83.90	202.50	202.50
\$300.....	105	112.40	157.50	168.60	86.70	92.80	236.40	240.00
\$350.....	116	124.20	174.00	186.30	95.70	102.50	254.10	266.10
\$400.....	127	135.90	190.50	203.90	104.80	112.20	254.10	286.80
\$466.....	(⁵)	149.90	(⁵)	224.90	(⁵)	123.70	(⁵)	312.00

¹ A revised and extended benefit table will become effective with January 1971, to take account of average monthly earnings up to \$550, the maximum average monthly earnings that will be possible under the \$6,600 contribution and benefit base that will be effective for years after 1970.

² For a worker age 65 or over at the time of retirement and a wife age 65 or over at the time when she comes on the rolls.

³ Survivor benefit amounts for a widow and 1 child or for 2 parents would be the same as the benefits for a man and wife.

⁴ For families already on the benefit rolls who are affected by the maximum-benefit provisions, the amounts payable under the bill would in some cases be somewhat higher than those shown here.

⁵ Not applicable, since the highest possible average monthly earnings amount is \$400.

The family maximum.—Under the bill, the maximum amount of benefits payable to a family would be related to the worker's average monthly earnings through the entire range as it now is at the lower levels. Under present law, the highest maximum family benefit is \$254, and this amount applies at all average monthly earnings levels above \$314. Under the bill, a different family maximum amount would be provided at every average monthly earnings bracket in the benefit table, from a minimum of \$66 to a maximum of \$312 under the \$5,600 contribution and benefit base and to a maximum of \$368 under the \$6,600 contribution and benefit base. The maximum amount payable to a family now on the benefit rolls would be \$286.80, as compared with \$254 under present law.

Effective date.—The 7-percent increase would be effective beginning with benefits for January 1965. The increased benefits would be paid retroactively to the 20 million beneficiaries who were on the rolls in January 1965 and to beneficiaries who came on the rolls after January 1965 and through the month of enactment of the bill, whether or not they are still on the rolls at the time of enactment. Lump-sum death payments based on deaths that occurred in the retroactive period would not be increased.

This is the first time that a general increase in social security benefits has been made retroactive. The present situation may be regarded as somewhat unique. As your committee stated last July in its report on H.R. 11865, a general increase in social security benefits was needed at that time. H.R. 11865, as passed by both Houses last year, provided for a general benefit increase and, if the bill had been enacted, it would have provided increased social security benefits that would have been effective at about the beginning of 1965. For reasons not related to the question of whether benefits should be increased, H.R. 11865 failed of passage last year. Your committee therefore recommends paying

the increased benefits retroactively to January, thus putting beneficiaries in the same relative position they would have been in if H.R. 11865 had been enacted.

Because of the magnitude of the task of converting the benefit rolls to the higher amounts, the first regular monthly check reflecting the 7-percent increase generally would be the check for the third month following the month of enactment.

To avoid the possibility of confusion on the part of beneficiaries as to the exact amount of the benefit increase, the increased benefits for the retroactive months would be paid in a separate check.

In 1965, an estimated \$1.2 billion in additional benefits would be paid as a result of the 7-percent increase; in 1966, \$1.4 billion in additional benefits would be paid.

2. PAYMENT OF CHILD'S INSURANCE BENEFITS TO CHILDREN ATTENDING SCHOOL OR COLLEGE AFTER ATTAINMENT OF AGE 18 AND UP TO AGE 22

Under present law a child beneficiary is considered dependent, and is paid benefits, until he reaches age 18, or after that age if he was disabled before age 18 and is still disabled. The committee believes that a child over age 18 who is attending school full time is dependent just as a child under 18 or a disabled older child is dependent, and that it is not realistic to stop such a child's benefit at age 18. A child who cannot look to a father for support (because the father has died, is disabled, or is retired) is at a disadvantage in completing his education as compared with the child who can look to his father for support. Not only may the child be prevented from going to college by loss of parental support and loss of his benefits; he may even be prevented from finishing high school or going to a vocational school. With many employers requiring more than a high school education as a condition for employment, education beyond the high school level has become almost a necessity in preparing for work.

Your committee believes it is now appropriate and desirable to provide social security benefits for children between the ages of 18 and 22 who are full-time students and who have suffered a loss of parental support. Students whose benefits have already terminated at age 18, as well as children currently on the rolls, would qualify for benefits under the provision. The median age of students graduating from high school is about 18; providing benefits up to age 22 would mean that for many children benefits could continue for the time it takes to complete a 4-year college course.

The term "school" is defined broadly to permit payments to students taking vocational or academic courses. The definition of school is intended to establish that the institution the child attends is a bona fide school. It includes all public school, colleges, and universities, as well as private, accredited institutions and private nonaccredited institutions whose credits are accepted by accredited institutions. In determining full-time attendance, the Secretary of Health, Education, and Welfare would take into account the standards and practices of the school involved. Specifically excluded would be an individual paid by his employer to attend school. Benefits would be paid during normal school vacation periods as well as during the school year.

The bill would not provide for the payment of mother's benefits to a mother whose only child is over 18 and getting benefits because he is

attending school. There is less need to pay benefits to the mother in such cases than in those where the child is under 18, since she is not required to stay at home to care for the child as she may have been when he was younger.

The provision for paying benefits to children aged 18-21 who are full-time students would be effective beginning with benefits for January 1965. Benefits would be paid retroactively to children who would have been eligible in January 1965 and to those who have become eligible since that time regardless of whether they are eligible in the month in which the bill is enacted. A provision similar to this was included in H.R. 11865, 88th Congress, which failed of passage for reasons entirely unrelated to the payment of benefits to children aged 18-21 who were full-time students. Your committee recognizes that the retroactive benefit payments cannot be made immediately after this bill is enacted since there may be some delay because of administrative problems.

An estimated 295,000 children would be eligible for benefits for September 1965, when the school year begins, and in 1966 about \$195 million in benefits would be paid.

3. BENEFITS FOR WIDOWS AT AGE 60

Under present law the earliest age at which a widow without eligible children can qualify for benefits based on the earnings of her deceased husband is 62. Many women are widowed years after having left the labor market to become housewives and mothers, and they lack the skills necessary to qualify for reasonably suitable employment. Women who are widowed in their late fifties and sixties are often denied employment because of their age.

The bill would provide for the payment of aged widow's benefits beginning at age 60, with the benefits actuarially reduced to take account of the longer period over which they would be paid. This provision would thus extend to these women a choice of applying for benefits at any time between age 60 and 62, with a reduced benefit, or of waiting until age 62 to receive a full widow's benefit. The amount of the reduction—five-ninths of 1 percent for each month before age 62 for which the benefit was paid—would be sufficient to assure that over the long run there will be no additional cost to the social security system as a result of the earlier payment of the benefits. If the widow chose to get her benefits starting at age 60 her benefit would be reduced by $13\frac{1}{3}$ percent; the reduced benefit would amount to $71\frac{1}{2}$ percent of the deceased husband's primary benefit (at age 62 the full benefit equals $82\frac{1}{2}$ percent of the deceased husband's primary widow's benefit).

An estimated 185,000 widows aged 60-61 on the effective date of this provision are expected to claim benefits during the first year of operation. Benefit payments would be about \$165 million in 1966.

4. AMENDMENTS OF DISABILITY PROGRAM

(a) Improvements in disability provisions

In 1956, Congress amended the Social Security Act to provide disability benefits for persons afflicted with disabilities of long-continued and indefinite duration and of sufficient severity to prevent a return to

any substantial gainful employment. In providing this protection against loss of earnings resulting from extended total disability, the Congress designed a conservative program. It was expected that, as experience under these provisions was gained, necessary improvements would follow. As a result, amendments enacted in 1958 and 1960 improved the disability program by, among other changes, extending benefits to wives and children of the disabled, and by providing for the payment of disability benefits to incapacitated workers under age 50 who had previously been excluded. Your committee believes that experience with the disability program since 1960 indicates that certain further improvements should be made at this time to broaden the protection provided by the program against the risk of extended total disability. The recommended improvements in the disability provisions would be adequately financed from the contributions your committee is recommending be earmarked for the disability insurance trust fund.

(1) *Elimination of the long-continued and indefinite duration requirement from the definition of disability*

Under present law, disability insurance benefits are payable only if the worker's disability is expected to result in death or to be of long-continued and indefinite duration. Your committee's bill would broaden the disability insurance protection afforded by the social security program by providing disability insurance benefits for an insured worker who has been totally disabled for at least 6 calendar months even though it is expected that he will recover in the foreseeable future. The modification in the definition recommended by your committee does not change, however, the requirement in existing law that an individual must by reason of his impairment be unable "to engage in any substantial gainful activity." In line with the original views expressed by your committee and since reaffirmed, to be eligible an individual must demonstrate that he is not only unable, by reason of a physical or mental impairment, to perform the type of work he previously did, but that he is also unable, taking into account his age, education, and experience, to perform any other type of substantial gainful work, regardless of whether or not such work is available to him in the locality in which he lives.

Your committee believes that the elimination of the requirement of indefinite duration from the definition of disability would help to meet the need for insurance protection of that substantially large group of disabled workers who, though totally disabled for an extended period, can be expected to eventually recover. For many of these disabled people, the payment of disability insurance benefits would mean the difference between financial independence and dependence on public assistance. Workers who contract tuberculosis, for example, can generally be expected to recover after a period of appropriate treatment. However, the period during which they may be unable to engage in any gainful work because of their condition may extend well over a year and many such workers are, during this protracted period, without the income they need to support their families. It is estimated that if benefits were payable for disabilities that are total and last more than 6 months but are not necessarily expected to last indefinitely about 155,000 additional people—workers

and their dependents—would become immediately eligible for benefits.

Your committee expects that, as now, procedures will be utilized to assure that the worker's condition will be reviewed periodically and reports of medical reexaminations obtained where appropriate so that benefits may be terminated promptly where the worker ceases to be disabled.

The elimination of the requirement that a determination be made that a disability can be expected to result in death or to be of long-continued and indefinite duration would bring the social security disability program into line with the prevailing practice in private disability insurance. Provisions much like the one which your committee is recommending, that is, providing for the payment of disability benefits on the basis of total disability throughout a continuous period of 6 months without regard to the expected duration of disability, serve as the basis for payment in the majority of private disability insurance contracts and in many other disability programs.

The elimination of the indefinite duration requirement would also clarify for beneficiaries their rights under the disability program and at the same time simplify administration and help to speed up the payment of the first benefit check to disabled workers in those cases where a medical determination about the duration of disability is difficult to make. Under present law, the need for such prognoses sometimes results in delays in filing, and occasionally in the failure to file for benefits when the applicant is uncertain about whether his disability can be expected to be permanent. In some cases, the need for a prognosis delays a determination of disability; in other cases, the application is denied initially because a favorable prognosis is made. While the prognosis may, in the latter case, ultimately prove erroneous and thus necessitate a reversal of the initial decision, payment is then made retroactively in a lump sum and not on a current basis when the benefits are most needed.

(2) Payment of a benefit for the sixth month of disability

Your committee is also recommending that entitlement to social security disability benefits begin at the end of the sixth month of continuous disability. Under the waiting period requirement in the present law, more than 7 months must pass after the onset of disability before the disabled worker can receive his first benefit check. By changing the present requirement so that the first month of entitlement to benefits would be the last month of the waiting period, the first benefit check would be payable for the sixth full month of disability. Thus, under this recommended change there would still be a wait of at least 6 months after onset of disability before the worker or his family could receive benefits, but the first disability check would be paid as quickly as possible after the 6-month waiting period.

(3) Payment of benefits for second disabilities without regard to waiting period

Your committee is also recommending a conforming modification in the provisions of present law under which disability benefits are paid without a waiting period in the case of a worker whose previous disability was terminated within 5 years before onset of his second disability. The purpose of the provision for the payment of disability benefits without regard to the waiting period in the case of a bene-

ficiary whose disability recurs within 5 years after the termination of a prior period of disability is to encourage disabled persons to return to work even though there may be a question as to whether their work attempts will be successful. Since many disability insurance beneficiaries who return to work do so despite severe impairments and are thus faced with the possibility that their work attempts may be unsuccessful, a 6-month qualifying period for reentitlement to benefits may be a real bar to any further work attempts. Under the provision recommended by your committee, benefits would be paid beginning with the first month of onset of the second or subsequent disability and without regard to the waiting period requirement only if the individual had a prior period of disability which lasted at least 18 calendar months and only if the subsequent period of disability can be expected, at the time of application, to last a continuous period of at least 12 months or to result in death. Your committee is recommending this change in order to limit the cases in which payment of benefits would be made without a waiting period to those situations where it is reasonable to presume in general that the second or subsequent disability constitutes a recurrence or aggravation of the previous disability and where the second or subsequent disability can be expected to be of extended duration.

Concern has been expressed about the payment of disability benefits concurrently with benefits payable under State workmen's compensation laws. Your committee is advised that under the present law the extent of excessive wage replacement resulting from overlapping benefits between workmen's compensation and social security disability benefits has not been significant. Moreover, a provision in the social security law for reducing disability benefits by the amount of any other benefit to which a worker was entitled under State workmen's compensation laws, which was in effect from July 1957 to July 1958, was repealed in 1958 because it was concluded that it operated in an inequitable and unsatisfactory manner. Nevertheless, your committee shares the belief of the Advisory Council on Social Security that it would be worth while to have additional information about the overlap and its effects.

We therefore request that the Social Security Administration proceed as rapidly as feasible with plans to conduct a study of the significance of overlapping benefits under the two programs. Such a study should produce information on: (1) the number and proportion of beneficiaries under each program who are receiving cash disability benefits under the other program; (2) the characteristics of persons receiving dual benefits as compared with those not receiving dual benefits; and (3) the extent to which combined payments under the two programs are effective in replacing lost earnings, both currently and for the future. Your committee requests that a report covering the results of this study and such other facts relating to the problem as are found relevant, be made to it on or before December 31, 1966. This report should also include recommendations as to whether action (and if so, what kind of action) should be taken under the Federal social security disability program or under the State workmen's compensation programs to control excessive payments in cases of dual entitlement, as well as the effect on costs to employers.

(b) Payment of disability insurance benefits after entitlement to other monthly insurance benefits

Under the hospital insurance benefit provisions of your committee's bill, a wife who is age 65 or over and whose husband is between the age of 62 and 65 and insured can qualify for hospital insurance, provided her husband files for actuarially reduced old-age insurance benefits. The husband may be working full time and not receive any of the old-age benefits. Under present law, he would be reluctant to file for old-age benefits because present law states that after a worker becomes entitled to old-age benefits he cannot subsequently qualify for disability benefits. If present law were unchanged, the worker would be faced with the choice of sacrificing either eligibility for disability protection or his wife's health insurance.

Your committee has, therefore, included in the bill a provision whereby a worker who becomes entitled to old-age benefits may subsequently, until he reaches age 65, become entitled to disability benefits. This provision would also eliminate the difficult question some beneficiaries have faced, even before the hospital insurance question arose, as to whether they should take actuarially reduced benefits or retain their rights to disability protection.

(c) Increase in allocation to the disability insurance trust fund

The bill would increase the contribution income allocated to the disability insurance trust fund from 0.50 to three-fourths of 1 percent of taxable wages and from 0.375 to nine-sixteenths of 1 percent of taxable self-employment income. This increase takes account of lower disability termination rates than were expected (disability insurance beneficiaries have been living somewhat longer than anticipated) and the increase in the cost of the disability insurance part of the program arising out of the changes made by the bill. The increase in the contribution income to the disability fund would bring the disability insurance part of the program into close actuarial balance.

5. PAYMENT OF BENEFITS TO CERTAIN PEOPLE AGED 72 OR OVER WHO ARE NOT OTHERWISE INSURED

Your committee believes that a special transitional insured status provision should be adopted so that social security benefits can be provided for those among the present aged who, though they worked in covered jobs, did not have an opportunity to work long enough to become insured under the program, and for their wives and widows. About 355,000 people would become eligible immediately for social security benefits under these provisions, with benefits payable under the provisions totaling about \$140 million in 1966.

The present law requires a minimum of six quarters of coverage for insured status; as a result, although the general requirement for insured status is one quarter of coverage for each year elapsing after 1950 and up to retirement age (65 for men, 62 for women), people who reached retirement age in 1956 or earlier must have more than one quarter for each year that elapsed after 1950 to qualify for benefits.

Under the bill the minimum would be three quarters of coverage rather than six, and therefore people who reached retirement age in 1954, 1955, or 1956 could qualify for benefits if they had one quarter of coverage for each year that elapsed after 1950 and up to retirement

age, and people who reached retirement age prior to 1954 could qualify if they had three quarters of coverage instead of six.

The following table shows the operation of the "transitional insured status" provision for workers:

Men		Women	
Age in 1965	Quarters of coverage required	Age in 1965	Quarters of coverage required
76 or over.....	3	73 or over.....	3
75.....	4	72.....	4
74.....	5	71.....	5

Wife's benefits would be payable at age 72 to a woman whose husband qualified for benefits under the transitional provision if she attained age 72 before 1969.

Widow's benefits would be payable at age 72 to a woman whose husband qualified for benefits under the transitional provision if she attained age 72 before 1969. Also, a widow whose husband had attained age 65 or died before 1957 without being insured could get benefits if the husband had a specified number of quarters of coverage, as shown in the following table:

Year of husband's death (or attainment of age 65, if earlier)	Quarters of coverage required under present law	Quarters of coverage required if the widow attains age 72 in—		
		1966 or earlier	1967	1968
1954 or before.....	6	3	4	5
1955.....	6	4	4	5
1966.....	6	5	5	5

Under these provisions the benefit amount for a worker would be \$35 per month; for his wife, \$17.50 per month; for his widow, \$35 per month. Benefits would be payable for and after the second month following the month of enactment.

6. LIBERALIZATION IN THE RETIREMENT TEST

The bill would change the provision in present law under which there is a \$1 reduction in benefits for each \$2 of earnings above \$1,200 and up to \$1,700 to provide for a \$1-for-\$2 reduction for earnings from \$1,200 to \$2,400. Benefits would continue to be reduced by \$1 for every \$1 of earnings above \$2,400, as they are now on earnings above \$1,700. This change would increase the incentive to work in the income range between \$1,700 and \$2,400 and would, in combination with the increase in benefits that the bill also provides, make possible a significant increase in annual income for many beneficiaries who are able to work and earn more than \$1,700.

Under present law a self-employed person who performs substantial services but who has no income from current work, can nevertheless have benefits withheld under the retirement test because he gets royalties attributable to a copyright or patent obtained in years before he at-

tained age 65. The bill would exclude for retirement test purposes royalties received by a self-employed person in or after the year in which he attained age 65 if those royalties are attributable to a copyright or patent obtained before the year in which he attained age 65. Royalties received by a beneficiary from a copyright or patent obtained in or after the year in which he attained age 65 would continue to be counted for retirement test purposes, as under present law, in the year in which they are received.

7. WIFE'S AND WIDOW'S BENEFITS FOR DIVORCED WOMEN

It is not uncommon for a marriage to end in divorce after many years, when the wife is too old to build up a substantial social security earnings record even if she can find a job. But under present law a wife's right to benefits on her husband's earnings record generally ends with a divorce. Under the present social security law, the only benefits provided for a divorced woman are mother's insurance benefits, and they are payable only if she has a child of the deceased worker in her care and the child is getting benefits on the basis of his deceased father's earnings, if she has not remarried, and if she had been getting at least one-half of her support from her former husband under a court order or agreement at the time of his death. A divorced wife without a child in her care cannot get benefits even though she had been dependent upon the worker for much of his working lifetime and he was contributing to her support when he retired or died.

Under the bill wife's or widow's benefits would be payable to an aged divorced woman on the basis of her former husband's earnings if the divorced woman (A) had been married to that former husband for 20 years before the divorce, (B) had not remarried, and (C) met the following support requirement at the time her former husband became disabled, became entitled to benefits or died; (1) she was receiving one-half of her support from her former husband, or (2) she was receiving substantial contributions from him pursuant to a written agreement, or (3) a court order for substantial contributions to her support from her former husband was in effect. A conforming change would be made in the support requirements that must be met by a former wife divorced (renamed "surviving divorced mother" in the bill) in order to qualify for mother's benefits based on the social security account of her deceased former husband.

Payment of a wife's or widow's benefit to a divorced woman would not reduce the benefits paid to any other person on the same social security account and such wife's or widow's benefit would not be reduced because of other benefits payable on the same account.

The bill would also provide that a wife's benefit will not terminate when she and her husband are divorced if they had been married for at least 20 years before the divorce.

Benefits for a divorced wife or a surviving divorced wife would not terminate on account of remarriage in those cases where widow's benefits under present law do not terminate—that is, where the remarriage is to a man getting benefits as a dependent widower or parent or as a disabled child aged 18 or over. If a divorced wife or a surviving divorced wife married an old-age insurance beneficiary, her benefits would terminate but she would immediately be eligible for wife's benefit on her new husband's account.

While the provisions just described would take care of cases in which the marriage had lasted for 20 years or more, they would leave unsolved the problem of the woman who is widowed or divorced after many years and is remarried but whose second marriage ends in divorce after less than 20 years. To meet this problem, the bill would further provide that a woman whose rights to benefits as a widow, divorced wife, surviving divorced wife, or surviving divorced mother were terminated because she remarried will have her former benefit rights restored if her second marriage ends in divorce after less than 20 years. This provision would provide protection for women whose second marriages end in divorce after they are along in years. The divorced woman who was age 62 or over and getting benefits before she remarried and the divorced woman whose former husband died when she was 50 and who later remarried would be among the women protected by the provision. Young women getting mother's benefits (including surviving divorced mothers) would also have protection in case their second marriages ended in divorce. In the case of a surviving divorced mother, the provision would not preclude her possible entitlement to benefits as a surviving mother on the basis of the earnings record of a second husband to whom she was married for a period of less than 20 years prior to divorce; under present law, a woman may be entitled to benefits on a man's earnings record as his former wife divorced if she has his child in her care even if she has not been married to him for 20 years, and the bill would not change that situation.

These changes would provide protection mainly for women who have spent their lives in marriages that are dissolved when they are far along in years—especially housewives who have not been able to work and earn social security benefit protection of their own—from loss of benefit rights through divorce.

8. ADOPTION OF CHILD BY RETIRED WORKER

Under present law, a child adopted by a worker who is already retired and getting old-age insurance benefits can become entitled to benefits even though he was not dependent on the worker at the time the latter retired. In contrast, present provisions governing the payment of child's insurance benefits to a child adopted by a person getting disability insurance benefits, and to a child adopted by the surviving spouse of a worker who has died, contain requirements designed to assure that benefits will be paid to such children only when there is a basis for assuming that the child lost a source of support when the worker became disabled or died.

Your committee believes that the provisions concerning adoptions by retired workers should be made comparable to those relating to adoptions in other cases so as to provide safeguards against abuse through adoption of children solely to qualify them for benefits, and has included in the bill a provision that would accomplish this result. Under this provision benefits would be payable to a child who is adopted by an old-age insurance beneficiary after the latter becomes entitled to benefits only if the following conditions are met:

- (1) At the time the worker became entitled to benefits the child was living with the worker or adoption proceedings had begun;
- (2) The adoption was completed within 2 years of the time when the worker became entitled to benefits; and

(3) The child had been receiving at least one-half of his support from the worker for the entire year before the worker became entitled to old-age insurance benefits or, if the worker had a period of disability which continued until he became entitled to old-age insurance benefits, before the beginning of the period of disability.

9. COVERAGE EXTENSIONS AND MODIFICATIONS

Your committee's bill would extend social security coverage to self-employment income from the practice of medicine, and to the wages of interns, cover tips as wages, facilitate coverage of additional State and local government employees, provide additional coverage for employees of certain nonprofit organizations, extend coverage to temporary employees of the District of Columbia, increase the amount of gross income which farmers may use under the optional method of computing farm self-employment income for social security purposes, and permit exemption from the social security self-employment tax for persons who follow certain teachings of a religious sect of which they are members.

(a) Coverage of self-employed physicians and interns

Self-employed doctors of medicine are the only group of significant size whose self-employment income is excluded from coverage under social security. Large numbers of doctors have requested coverage. Your committee knows of no valid reason why this single professional group should continue to be excluded. It runs counter to the general view that coverage should be as universal as possible. There are no technical or administrative barriers to the coverage of self-employed doctors of medicine.

Moreover, more than half of the physicians in private practice have obtained some social security credits through work other than their self-employment as physicians, or through their military service. As indicated, many requests for coverage have been received from those who have not obtained social security credits in this way and from physicians who have some credits but wish to obtain full social security protection.

Your committee's bill would cover the self-employment income of the approximately 170,000 self-employed doctors of medicine on the same basis as the self-employment income of other professional groups, effective for taxable years ending after December 31, 1965.

Coverage would also be extended to services performed by medical and dental interns. The coverage of services as an intern would give young doctors an earlier start in building up social security protection and would help many of them to become insured under the program at the time when they need the family survivor and disability protection it provides. This protection is important for doctors of medicine who, like members of other professions, in the early years of their practice, may not otherwise have the means to provide adequate survivorship and disability protection for themselves and their families. Interns would be covered on the same basis as other employees working for the same employers, beginning on January 1, 1966.

(b) Computation of self-employment income from agriculture

Under present law, persons with net earnings from farm self-employment have the following option in reporting for social security purposes: (a) If annual gross income from agricultural self-employment is not over \$1,800, either actual net earnings or 66⅔ percent of gross income may be reported; (b) if gross income from agricultural self-employment is over \$1,800 and net earnings are less than \$1,200, either net earnings or \$1,200 (two-thirds of \$1,800) may be reported; and (c) if the annual gross income is more than \$1,800 and net earnings are \$1,200 or more, actual net earnings must be reported.

The bill approved by your committee would retain the present option in the reporting of farm self-employment income but would raise the level of income which may be reported under the gross income option by increasing the \$1,800 figure to \$2,400 and the \$1,200 figure to \$1,600.

Thus, persons with agricultural self-employment would be permitted to use the following option in reporting their earnings from agricultural self-employment for social security purposes: (a) If annual gross income from agricultural self-employment is not over \$2,400, either actual net earnings or 66⅔ percent of gross income may be reported; (b) if gross income from agricultural self-employment is over \$2,400 and actual net earnings are less than \$1,600, either actual net earnings or \$1,600 may be reported; and (c) if gross earnings are more than \$2,400 and net earnings are more than \$1,600, the actual net earnings must be reported. This change would be effective for taxable years beginning after December 31, 1965.

(c) Coverage of tips

The problem of extending social security coverage to tips has engaged the attention of your committee for many years. The principal difficulty has been to devise a fair and practical system for obtaining information on amounts of tips received by an individual which could serve as a basis for contributions and benefit credits. Another problem has been the question of whether tips should be taxed as wages or as self-employment income.

It is a matter of common knowledge that in occupations where employees customarily receive tips, the regular wages of these employees are generally far below those of other employees with comparable training and duties. It was reported to the committee, for example, that under a bargaining agreement covering hotel employees in a large city the wages of waiters and waitresses were about 30 percent under those of a dishwasher, one of the lowest paid kitchen workers, and the wages of bellhops were one-half of those of reservation clerks. On the basis of such wage and tipping practices, the committee has concluded that it would be appropriate to treat tips as wages for social security purposes.

The committee has also decided that the only equitable way of counting tips toward benefits is on the basis of actual amounts of tips received and that the only practical way to get this information is to require employees to report their tips to the employer. Other methods for determining a tax and credit base for tips were considered previously, but the agencies directly concerned with the problems concluded that no other approach would assure better coverage

or compliance. Your committee agrees with this and has adopted in this bill the reporting plan approved last year in H.R. 11865.

On the average about one-third of the work income of employees who receive tips in the course of employment is in the form of tips; for many, tips constitute the major source of earnings. Since the regular wages of employees who customarily receive tips are relatively low, the benefits based on those wages are low. For example, under the benefit provisions of the bill, a person getting regular wages of \$35 a week and averaging another \$35 in tips would get a monthly retirement benefit, beginning at age 65, of \$79.20 if only his regular wages were counted. If his tips could also be counted, his benefit amount would be \$113.50.

Coverage of tips will provide better protection under the social security program for more than a million employees and their dependents. The amount of tips received by employees who regularly receive tips is estimated at more than \$1 billion a year. Under existing law, only a small fraction of this amount may now be counted toward social security. Information has been presented to indicate that only a small fraction of this amount is now reported for income tax purposes. Because the extension of social security coverage to tips should result in better reporting of all tips for income tax purposes, it seems only fair to allow employees whose earnings are principally from tips to use the pay-as-you-go (withholding) system for paying the income tax on their tips and to have employers collect this tax from the regular wages. Your committee's bill, therefore, provides for the collection of income tax from wages on tips reported to the employer.

Under the bill, tips received by an employee (on his own behalf) in the course of his employment would be covered as wages. The employee would be required to report to his employer in writing the amount of tips received and the employer would report the employee's tips along with the employee's regular wages. The employee's report to his employer would include tips paid to him through the employer as well as those received directly from customers of the employer. To avoid requiring employees and employers to report small amounts of tips that might be burdensome on employers and that would not ordinarily have a significant effect on the employee's benefit amount, tips received by an employee which do not amount to a total of \$20 a month in connection with his work for any one employer would not be covered and would not be reported.

The employer would be responsible for collecting the employee's share of the social security tax on tips, paying his (the employer's) share of the tax, and including the tips with his report of wages only if the employee reported the tips to him, in writing, within 10 days after the end of the month in which the tips were received, and then only to the extent that he had available unpaid cash wages of the employee, or funds the employee turned over to him for that purpose, that were sufficient to cover the employee's share of the tax. As a convenience to the employer, a provision is included under which he would be permitted to withhold the employee's share of the social security tax from current wages on the basis of an estimated amount of tips and to adjust the amount withheld at the end of each quarter to conform to the amount actually due on the basis of the employee's written statement of his tips. This provision will permit the employer

to gear these new reporting procedures into his usual payroll periods. The amount of tips reported by the employer for the employee in his quarterly report of wages paid to employees would, of course, be the amount of tips which the employee reported to his employer for the calendar quarter and on which the employer could withhold the employee's share of the social security tax. Also, provision is made authorizing an employer who is furnished a written statement of tips to deduct from the employee's wages the employee's tax on the tips included in the statement, even though at the time the statement is furnished the total amount of tips received so far in the month is less than \$20.

Although the employer would have no liability with respect to tips which were not reported to him within the time specified in the bill and with respect to which he could not collect the employee tax out of unpaid wages or funds turned over by the employee, such tips, nevertheless, would be covered. In such case, the employee would be liable for the employee's share of the social security tax and—unless he could show reasonable cause for failure to provide the employer with a written statement of his tips and make available to the employer the employee's share of the tax due on such tips—an additional amount equal to that tax.

The bill further provides that the employees' tips are to be subject to income tax withholding. Under present income tax law, tips are considered compensation for services and are includible in gross income. Your committee is advised that a very substantial number of tip recipients do not report all their tips, and that many report none at all. For example, in a recent survey conducted by the Internal Revenue Service covering 154 tip employees in 5 restaurants and 2 hotels of a large northern city, practically all employees had reported only their regular wages and no tips on their tax returns. One-third of these employees have since agreed to tax deficiencies averaging \$450. The others have been assessed deficiencies averaging \$600 per taxpayer. In the opinion of your committee, if tips are to be covered under social security as wages they should also be treated as wages for purposes of the collection of tax at source.

Under present law, employees who receive tips should be paying the income tax due on their tips on an estimated quarterly basis as do other taxpayers who receive income from sources where the income tax is not collected by the payer. It is a difficult problem for the average tip recipient to comply with this requirement in the law because of the informal manner in which he receives numerous tips. But even if compliance could be expected, the payment in one lump sum at 3-month intervals of the estimated tax due on tips received during such 3-month period would be a considerable burden on these employees, the great majority of whom are in the lower income brackets and would have difficulty in budgeting to pay these quarterly amounts. A proper, convenient and easy solution is to offer these employees the opportunity to pay their income tax on tips currently by having the employer withhold the tax from the employee's regular wages.

In general, the employer would follow the same procedures for income tax withholding as for social security purposes. The employer's liability for withholding income tax, however, would be limited to funds of the employee that are in the employer's possession before the close of the calendar year in which the tips were received and that are

in excess of the amount of social security taxes to be collected. There would be no obligation on the part of the employee to ensure that the employer had sufficient funds of the employee to be able to deduct the full amount of the income tax required to be withheld. In most instances the employee's wages would be more than adequate to cover the social security tax and the income tax withholding. A weekly wage of only \$12 for a single person would be more than enough to cover the social security and income taxes due on combined tip and wage earnings of \$62. This would represent tips at a rate of \$1.25 an hour for a 40-hour week which are above average earnings since 60 percent of waiters and waitresses in the United States earn under \$1.25 an hour in tips, according to a 1961 Bureau of Labor Statistics survey.

Tips received by self-employed people are covered under present law as income from self-employment for social security purposes. In providing this method for covering tips received by employees it is not intended that this action of the committee change the employment status of any one who receives tips or change the treatment of tips received by the self-employed.

(d) Coverage provisions applying to employees of States and localities

(1) Addition of Alaska and Kentucky to the States which may provide coverage through division of retirement systems

Under a provision of the Social Security Act which is designed to facilitate the extension of social security coverage to members of State and local government retirement systems, 18 specified States (and all interstate instrumentalities) are permitted to divide a State or local government retirement system into two parts for purposes of social security coverage, one part consisting of the positions of members who desire coverage, and the other consisting of the positions of members who do not desire coverage. Services performed by employees in the part consisting of the positions of members who desire coverage may then be covered under social security, and once those services are covered, the services of all persons who in the future become members of the retirement system must also be covered. The 18 States which are now permitted to extend coverage under this provision are California, Connecticut, Florida, Georgia, Hawaii, Massachusetts, Minnesota, Nevada, New Mexico, New York, North Dakota, Pennsylvania, Rhode Island, Tennessee, Texas, Vermont, Washington, and Wisconsin. Your committee's bill would add Alaska and Kentucky to this group of States.

(2) Facilitating coverage under the provision for division of State and local government retirement systems

The bill would provide a further opportunity for election of social security coverage by employees of States and localities who did not elect coverage when they previously had the opportunity to do so under the provision permitting specified States to cover only those members of a retirement system who desire coverage. Under the present provision, the specified States may, during the 2-year period after coverage of a group is approved, cover additional employees who request coverage. (However, employees hired after coverage of the group is originally approved are covered on a compulsory basis.) The bill would reopen, or hold open, through December 31, 1966, the opportunity for election of coverage by those employees who had not elected

coverage before the expiration of the 2-year period following approval of the coverage of their group.

Your committee recognizes that employees who initially failed to elect coverage under the divided retirement system provision were provided two subsequent opportunities for election of coverage under amendments made to the Social Security Act in 1958 and 1961. Although in general it is important that the time limits for electing coverage be maintained and that it be known they will be maintained, this situation involves special circumstances which seem to your committee to justify providing one additional opportunity. Your committee believes, however, that in the future there should be no further reopening of the opportunity for electing coverage under the divided retirement system provision beyond that which would be provided under this bill. We urge that those now contemplating participation in the program take timely action to exercise their choice.

The social security coverage of employees obtaining coverage as a result of the further opportunity provided by the proposed amendment would be required to begin on the same date as was provided when their group was originally covered.

(3) Coverage for certain additional hospital employees in California

The bill would modify a provision of the Social Security Amendments of 1960 which made coverage under the social security program available to certain hospital employees in the State of California who had performed services at some time during the period from January 1, 1957, through December 31, 1959, with respect to which contributions had been erroneously paid to the Internal Revenue Service prior to July 1, 1960. The 1960 legislation provided for crediting the remuneration which had been erroneously reported during the 1957-59 period, and for covering the services performed after 1959 by the individuals for whom the erroneous reportings had been made. Your committee's bill would make it possible for the State to provide coverage, beginning with January 1, 1962, for the services of hospital employees employed in the positions in question after 1959, and to secure the crediting of remuneration erroneously reported for them for periods prior to 1962 if contributions with respect to such remuneration have been paid before the enactment of the bill. The State would have 6 months after the month of enactment in which to provide such coverage.

The individuals who would be affected by your committee's bill could not be covered under the 1960 legislation, since they were not in the group for which erroneous reports had been filed during the 1957 through 1959 period. And, like the employees to whom the 1960 legislation applied, they cannot be covered under the generally applicable provisions of the Social Security Act providing coverage for employees of States and localities.

Generally speaking, the Social Security Act does not permit States to bring under social security coverage persons whom the States have removed from coverage under a State and local retirement system. The positions of the employees in question were removed from coverage under the California State employees retirement system effective July 1, 1957, without awareness that this section established a bar to future social security coverage. This misunderstanding led to the erroneous reports, and created the need for the 1960 amendment.

The employees to whom the bill is directed have the same need for coverage as those to whom the 1960 legislation applied, and are barred from coverage under the general provisions of law in the same way as were the employees covered by the 1960 legislation. Your committee believes that they should be given the same opportunity to obtain protection under the social security program as was given in 1960 to hospital employees in a similar situation.

(e) Tax exemption for members of a religious group opposed to insurance

Your committee's bill would permit exemption from the social security self-employment tax of individuals who have conscientious objections to insurance (including social security) by reason of their adherence to the established tenets or teachings of a religious sect (or division thereof) of which they are members. The exemption could be granted with respect to taxable years beginning after December 31, 1950.

The sect (or division thereof) must be one that has been in existence at all times since December 31, 1950, and has for a substantial period of time been making reasonable provision for its dependent members. To qualify as grounds for the tax exemption, the objections of the individual and the sect (or division thereof) to insurance must include objections to acceptance of the benefits of any private or public insurance which makes payments in the event of death, disability, old-age, or retirement or makes payments toward the cost of, or providing services for, medical care (including the benefits of any insurance system established by the Social Security Act). Before an individual could be granted exemption he would be required to waive all benefits and other payments under any insurance system established by the Social Security Act on the basis of his own earnings as well as all such benefits and other payments to him based on the earnings of any other person. The exemption could not be granted to any person who has been entitled to social security benefits, or to one whose earnings have provided the basis for entitlement to social security benefits for any other person. An individual's exemption (and the waiver of social security benefits) would be terminated if, and as of the time, the conditions under which the exemption was granted are no longer met, and the individual could not again be granted an exemption.

Your committee believes that provisions for coverage under social security on an individual voluntary basis are undesirable, and we have been reluctant to recommend an amendment which would permit an individual to elect exemption from social security coverage. Present law provides no exemption by reason of an individual's religious beliefs. The voluntary coverage provisions for ministers are applicable only to ministerial services; a minister who does other work is covered on the same basis as any other person. We believe that an exemption from social security taxes with respect to work that is generally covered would be justifiable only in cases where it is amply clear that an individual cannot accept the benefits of insurance, including social security benefits, without renouncing basic tenets of his religion. The exemption we are recommending is designed to be granted in only such cases. The proposed exemption would be limited to the self-employment tax under social security since those persons

for whom the payment of social security taxes appears to be irreconcilable with their religious convictions also, by reason of their religious beliefs, limit their work almost entirely to farming and to certain other self-employment.

We believe that the proposed exemption must be on the basis of individual choice. To exclude all members of a religious group from social security coverage would not take account of the variances in individual beliefs within any religious group, and would deny social security protection to those individuals who want it. Among the Old Order Amish, for example, there have been some indications of a change in attitude toward social security, particularly among the younger people; some members of the Old Order Amish who have become eligible for social security benefits have claimed the benefits.

Your committee believes that the recommended provision would provide relief for those individuals who sincerely believe that payment of social security taxes is irreconcilable with their religious convictions. We strongly recommend against any broadening of the proposed amendment since any such broadening could well lead to widespread individual voluntary coverage under social security, which would undermine the soundness of the social security program.

(f) Additional retroactive coverage of nonprofit organizations, and validation of coverage of certain employees of such organizations

Under present law the employees of a nonprofit organization may be covered under social security only if the employing organization files a certificate waiving its exemption from social security coverage. Your committee has learned that in some cases organizations have been reporting their employees for social security purposes without ever having filed the required waiver certificate. Such reports may be submitted for some time before the organization learns that they are erroneous. In such cases, employees who have been counting on having social security protection on the basis of their employment with such organization may in fact not have that protection.

Your committee's bill would permit a nonprofit organization to elect social security coverage to be effective for a period of up to 5 years (rather than 1 year, as under present law) before the calendar quarter in which the waiver certificate electing social security is filed. In addition, nonprofit organizations which had filed a waiver certificate in or prior to the year in which the bill is enacted would be given until the end of the year following enactment to amend their certificate to make social security coverage effective for a period of up to 5 years before the calendar quarter in which the amendment to the waiver certificate is filed.

Thus, by making its waiver certificate sufficiently retroactive, a nonprofit organization that had been erroneously reporting earnings for its employees without having filed a certificate to elect coverage could ordinarily provide complete and continuous social security coverage for the erroneously reported employees. That is, a nonprofit organization which learns of its erroneous reporting could file a certificate electing coverage and make it sufficiently retroactive to cover the period for which employee earnings already reported would otherwise be stricken from the record because the statute of limitations had not run when the erroneous reporting had been discovered. The effect of the social security statute of limitations is that in most cases correction of

an employee's social security earnings record may be made only if the error is discovered within 3 years, 3 months, and 15 days following the end of the year in which the wages were erroneously paid. Your committee's bill would, then, resolve on a permanent basis troublesome problems which have arisen under the nonprofit coverage provisions.

Your committee's bill also amends section 105(b) of the Social Security Amendments of 1960, which provided that an employee of a nonprofit organization could, under certain circumstances, receive credit for erroneously reported wages. The amendment applies to employees who are no longer in the employ of an organization when the waiver certificate is filed. These persons cannot be covered under the general provisions for retroactive coverage, as retroactive coverage is available only to persons still in the employ of an organization when the waiver certificate is filed. The amendment would permit such employees to have validated the reports of wages which had erroneously been made for them by the organization during the period of retroactive coverage. These persons have the same need for social security protection as those who are still employed by the organization when it files its waiver certificate.

(g) Coverage of certain employees of the District of Columbia

Under the present provisions of the Social Security Act, all service performed in the employ of the District of Columbia is excluded from social security coverage. Most District employees are covered under the Federal civil service retirement system or one of the two District retirement systems. Substitute teachers, however, are not covered under any government retirement system. Under your committee's bill, the District of Columbia could provide social security coverage for them. In addition, the bill would make it possible for the District of Columbia to cover under social security temporary or intermittent employees who are not now covered under the civil service retirement system but because of the temporary nature of their employment. The earliest date on which coverage could become effective would be the first day of the calendar quarter following the calendar quarter of enactment.

(h) Special study relating to Federal employees

The Committee on Ways and Means is aware that the single largest group of our citizens whose employment by law is precluded from social security coverage are the employees of the Federal Government. Your committee has given attention to this problem from time to time over a period of several years. Extensive consideration was given in 1960 to extending some form of social security coverage to Federal employees. At that time, it was concluded, on the recommendation of the Department of Health, Education, and Welfare and the Social Security Administration, that further opportunity should be afforded to the departments and agencies of the executive branch to give further study to the matter and present a coordinated recommendation to the Congress. Therefore, in lieu of statutory action, the Committee on Ways and Means at that time, in its report on the bill which became the Social Security Amendments of 1960 (H. Rept. 1799, to accompany H.R. 12580, 86th Cong.) urged the interested departments and agencies of the executive branch to "accelerate their efforts in finding a workable and sound solution to this problem and report it to the Congress at the earliest opportunity."

The report which was requested by the committee in 1960 regrettably was not received until a few days ago. Obviously, there was inadequate time on the part of the committee to study fully the suggestions contained in the report. The committee did not include provisions in this legislation in view of the lack of adequate time to study the report just presented to it.

Your committee has been advised by the Department of Health, Education, and Welfare that the executive branch has initiated a comprehensive study of retirement provisions for Federal personnel and that this study is to include further consideration of the proper role which should be played by social security, the civil service retirement program, and other staff retirement programs in the protection afforded Federal personnel.

In the light of all the foregoing, your committee has agreed to withhold recommendations until this further study is received despite the interest of many Members in closing this gap in the protection of civil service employees compared to that of employees in private industry. Your committee was advised that this study would be completed not later than December 1, 1965. It is your committee's expectation that that time table will be met.

10. EXTENSION OF PERIOD FOR FILING PROOF OF SUPPORT AND APPLICATION FOR LUMP-SUM DEATH PAYMENT

The law provides that the proof of support required for husband's, widower's and parent's insurance benefits, and applications for lump-sum death payments, must be filed within a 2-year period specified in the law. An extension of an additional 2 years is allowed where there was good cause for failure to file within the initial 2-year period. Many instances have arisen where there has been failure to file the required documents within the time allowed. A number of private bills have been proposed, and some enacted, to except specific individuals from this requirement in the law.

Believing that it is more desirable to provide for these situations by a provision of general law, your committee has included an amendment under which, if it is shown to the satisfaction of the Secretary of Health, Education, and Welfare that there was good cause for failure to file within the initial 2-year period, an applicant would be allowed to file proof of support or an application for a lump-sum death payment at any time.

11. AUTOMATIC RECOMPUTATION OF BENEFITS

Under the bill provision is made for automatic annual recomputation of benefits to take account of earnings that a beneficiary may have after he comes on the rolls and that would increase his benefit amount. Under present law, benefit recomputations to take account of additional earnings generally are available only on application, and can be made only if the worker had covered earnings of more than \$1,200 in a calendar year after he became entitled to benefits.

Experience has shown that a large number of people who are eligible for benefit recomputations to take account of additional earnings, and who will profit from such recomputations, fail to apply for them. Automatic recomputation would assure the beneficiary that he will get

credit for any earnings that would increase his benefit amount. Your committee has been advised that with the improved electronic equipment that is now used to compute benefit amounts, it is both feasible and administratively advantageous to handle these recomputations on an automatic basis.

An additional effect of the change would be to assure that no one would be disadvantaged by applying for benefits at age 65 instead of waiting until a somewhat later age. Under present law, in some few cases a worker who delays the filing of his application gets a larger benefit than he would have gotten if he had applied at age 65. In certain situations, therefore, people do not know whether to apply for benefits or to defer filing. Sometimes they do apply and it turns out to have been disadvantageous. Under the provisions in the bill it will be possible to assure every claimant that he cannot lose by applying at age 65.

12. REIMBURSEMENT OF THE TRUST FUNDS FOR THE COST OF MILITARY SERVICE CREDITS

Military service was not covered under the social security program on a contributory basis until 1957. However, special benefits were provided for the survivors of World War II veterans who died within 3 years after discharge, and noncontributory wage credits were provided under the program for active military service from September 16, 1940, through December 1956. The old-age and survivors insurance trust fund has been reimbursed for the cost of the benefits paid through August 1950, in the amount of about \$15 million. However, although present law provides that the costs incurred through June 30, 1956, were to have been paid into the trust funds over the 10 fiscal years ending June 30, 1969, and that the costs incurred by the payment of such benefits after June 1956 were to have been appropriated annually, no such payments have been made.

Your committee believes that it would be desirable to amortize the amounts owing over a period longer than the 10-year period provided under present law. The bill would authorize a level annual appropriation from general revenues to the trust funds starting in fiscal year 1966, that would amortize both the accumulated backlog and the additional amounts that will accrue through fiscal year 2015. After 2015, annual appropriations would be authorized to pay any additional costs.

13. FINANCING PROVISIONS

(a) Increase in the contribution and benefit base

The bill would raise from \$4,800 to \$5,600, beginning with 1966, and to \$6,600, beginning with 1971, the limitation on the amount of annual earnings that is used in determining benefits and that is subject to tax for the support of the program. The increases in the contribution and benefit base will make it possible to provide, for workers at and above average earnings levels, benefits that are more reasonably related to their actual earnings, and, by taxing a larger proportion of the Nation's growing payrolls, will improve the financial base of the program.

Even though higher benefits are provided on the basis of the additional earnings that are taxed and credited for social security pur-

poses, an increase in the contribution and benefit base results in a reduction in the overall cost of the social security program as a percent of taxable payrolls.

(b) Changes in the contribution rates

Consistent with the policy of maintaining the program on a financially sound basis that has always been followed in the past, the bill makes full provision for meeting the cost of the improvements it would make in the OASDI programs. Additional income would result from increasing the earnings base to \$5,600 in 1966 and \$6,600 in 1971 and from the extensions of coverage provided under the bill. In addition, your committee is recommending a revised contribution rate schedule.

Your committee has paid particular attention to the effect social security taxes might have on the individual taxpayer and the economy as a whole. Therefore, the schedule of contribution rates included in the bill, while it will produce sufficient income to finance the social security program, at the same time will avoid increases in the trust funds at a time when the economic impact of trust fund increases would be uncertain. Under the schedule of rates your committee recommends, no contribution rate increase after 1966 would go into effect at the same time as a contribution base increase, and the tax rate increase for old-age, survivors, and disability insurance scheduled to go into effect in 1966 would be somewhat lower than the one scheduled under the present law. Also, old-age, survivors, and disability insurance contributions for the self-employed person would be held at 6.0 percent of self-employment income through 1968 rather than increasing to 6.1 percent in 1966 and to 6.9 percent in 1968; after 1973 the contribution rate for the self-employed would be only one-tenth of 1 percent higher than scheduled under present law.

The present and proposed contribution rates for old-age, survivors, and disability insurance are as follows:

Year	Contribution rates (in percent)			
	Employer and employee, each		Self-employed	
	Present law	Bill	Present law	Bill
1966-67.....	4.125	4.0	6.2	6.0
1968.....	4.625	4.0	6.9	6.0
1969-72.....	4.625	4.4	6.9	6.6
1973 and after.....	4.625	4.8	6.9	7.0

14. ADVISORY COUNCIL ON SOCIAL SECURITY

The bill would repeal the present provisions for the appointment of future Advisory Councils on Social Security Financing and provide instead for the appointment of Advisory Councils of broader scope and of somewhat different representation.

The Councils provided for under present law are, in general, required to report only on the financing of the program. The Council that was appointed in 1963 and made its report on January 1 of this year was the only Council required to present its findings and recommendations with respect to all aspects of the program. That Council

urged that "every 5 years or so Advisory Councils be formed to review the substantive provisions of the program as well as its financing." Your committee agrees with this recommendation, and under the bill the scope of future Advisory Councils would be broadened so that all future Councils would report on all aspects of the program (including the new hospital insurance and supplementary health insurance programs established under the bill) and on their impact on the public assistance programs.

Present law requires that the Councils be composed of 12 members representing employers and employees in equal numbers and self-employed persons and the public. The bill provides that the Council members shall, to the extent possible, represent employer and employee organizations in equal numbers and self-employed persons and the public.

The Councils would submit their reports to the Secretary of Health, Education, and Welfare for transmission to the Congress and to the Board of Trustees. Under the time schedule for the appointment of Advisory Councils now in the law, Councils are to be appointed in 1966 and every fifth year thereafter and report on January 1 of the second year after the year of appointment. This schedule was designed so that a Council would report 1 year before each tax increase, and every fifth year after the final increase. In 1961 the final tax increase, previously scheduled for 1969, was rescheduled for 1968. As a result, the Council to be appointed in 1966 is required to make its report on the day on which the final rate increase now in the law is scheduled to go into effect. Under the bill, the next Advisory Council would be appointed in 1968 and make its report not later than January 1, 1970. Subsequent Councils would be appointed so as to report in 1975 and every fifth year thereafter.

15. ACTUARIAL COST ESTIMATES FOR THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEM

(a) Summary of actuarial cost estimates

The old-age, survivors, and disability insurance system, as modified by your committee's bill, has an estimated cost for benefit payments and administrative expenses that is very closely in balance with contribution income. This also was the case for the 1950 and subsequent amendments at the time they were enacted.

The old-age and survivors insurance system as modified by your committee's bill has been shown to be not quite self-supporting under the intermediate-cost estimate. Nevertheless, there is close to an exact balance, especially considering that a range of variation is necessarily present in the long-range actuarial cost estimates and, further, that rounded tax rates are used in actual practice. Accordingly, the old-age and survivors insurance program, as it would be changed by your committee's bill, is actuarially sound.

The separate disability insurance trust fund, established under the 1956 act, shows a favorable actuarial balance of 0.04 percent of taxable payroll under the provisions that would be in effect after enactment of your committee's bill, because the contribution rate allocated to this fund is slightly more than the cost of the disability benefits, based on the intermediate-cost estimate. Considering the

variability of cost estimates for disability benefits, this small actuarial surplus is not significant. The disability insurance program, as it would be modified by your committee's bill, is actuarially sound.

(b) *Financing policy*

(1) *Contribution rate schedule for old-age, survivors, and disability insurance in bill*

The contribution schedule for old-age, survivors, and disability insurance contained in your committee's bill is lower than that under present law by 0.25 percent in the combined employer-employee rate in 1966-67, is lower by 1.25 percent in 1968, is lower by 0.45 percent in 1969-72, and is higher by 0.35 percent in 1973 and thereafter. The maximum earnings base to which these tax rates are applied is \$5,600 per year for 1966-70 and \$6,600 for 1971 and after under your committee's bill as compared with \$4,800 under present law. These tax schedules are as follows:

Calendar year	[Percent]			
	Present law		Committee bill	
	Employee rate (same for employer)	Self-employed rate	Employee rate (same for employer)	Self-employed rate
1965.....	3.625	5.4	3.625	5.4
1966-67.....	4.125	6.2	4.0	6.0
1968.....	4.625	6.9	4.0	6.0
1969-72.....	4.625	6.9	4.4	6.6
1973 and after.....	4.625	6.9	4.8	7.0

The allocation rates to the two trust funds that are applicable to the combined employer-employee contribution rate for the bill, as compared with present law, are as follows:

Calendar year	[Percent]			
	Old-age and survivors insurance		Disability insurance	
	Present law	Committee bill	Present law	Committee bill
1965.....	6.75	6.75	0.50	0.50
1966-67.....	7.75	7.25	.50	.75
1968.....	8.75	7.25	.50	.75
1969-72.....	8.75	8.05	.50	.75
1973 and after.....	8.75	8.85	.50	.75

(2) *Self-supporting nature of system*

The Congress has always carefully considered the cost aspects of the old-age, survivors, and disability insurance system when amendments to the program have been made. In connection with the 1950 amendments, the Congress stated the belief that the program should be completely self-supporting from the contributions of covered individuals and employers. Accordingly, in that legislation the provision permitting appropriations to the system from general revenues of the Treasury was repealed. This policy has been continued in subsequent amendments. The Congress has always very strongly believed that the tax schedule in the law should make the system self-supporting as nearly as can be foreseen and actuarially sound.

(3) *Actuarial soundness of system*

The concept of actuarial soundness as it applies to the old-age, survivors, and disability insurance system differs considerably from this concept as it applies to private insurance and private pension plans, although there are certain points of similarity with the latter. In connection with individual insurance, the insurance company or other administering institution must have sufficient funds on hand so that if operations are terminated, it will be in a position to pay off all the accrued liabilities. This, however, is not a necessary basis for a national compulsory social insurance system and, moreover, is not always the case for well-administered private pension plans, which may not have funded all the liability for prior service benefits.

It can reasonably be presumed that, under Government auspices, such a social insurance system will continue indefinitely into the future. The test of financial soundness, then, is not a question of whether there are sufficient funds on hand to pay off all accrued liabilities. Rather, the test is whether the expected future income from tax contributions and from interest on invested assets will be sufficient to meet anticipated expenditures for benefits and administrative costs. Thus, the concept of "unfunded accrued liability" does not by any means have the same significance for a social insurance system as it does for a plan established under private insurance principles, and it is quite proper to count both on receiving contributions from new entrants to the system in the future and on paying benefits to this group. These additional assets and liabilities must be considered in order to determine whether the system is in actuarial balance.

Accordingly, it may be said that the old-age, survivors, and disability insurance program is actuarially sound if it is in actuarial balance. This will be the case if the estimated future income from contributions and from interest earnings on the accumulated trust fund investments will, over the long run, support the disbursements for benefits and administrative expenses. Obviously, future experience may be expected to vary from the actuarial cost estimates made now. Nonetheless, the intent that the system be self-supporting (and actuarially sound) can be expressed in law by utilizing a contribution schedule that, according to the intermediate-cost estimate, results in the system being in balance or substantially close thereto.

Your committee believes that it is a matter for concern if the old-age, survivors, and disability insurance system shows any significant actuarial insufficiency. Traditionally, the view has been held that for the old-age and survivors insurance portion of the program, if such actuarial insufficiency has been no greater than 0.25 percent of payroll, when measured over perpetuity, it is at the point where it is within the limits of permissible variation. The corresponding point for the disability insurance portion of the system is about 0.05 percent of payroll (lower because of the relatively smaller financial magnitude of this program). Based on the recommendation of the 1963-64 Advisory Council on Social Security Financing (see app. V of the 25th Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, H. Doc. No. 100, 89th Cong.), the cost estimates are now being made on a 75-year basis, rather than on a perpetuity basis. On this approach, the margin of variation from exact balance should be smaller—no more than 0.10 percent of

taxable payroll for the combined old-age, survivors, and disability insurance program.

Furthermore, traditionally when there has been an actuarial insufficiency exceeding the limits indicated, any subsequent liberalizations in benefit provisions were fully financed by appropriate changes in the tax schedule or through raising the earnings base, and at the same time the actuarial status of the program was improved.

The changes provided in your committee's bill are in conformity with these financing principles.

(c) Basic assumptions for cost estimates

(1) General basis for long-range cost estimates

Benefit disbursements may be expected to increase continuously for at least the next 50 to 70 years because of such factors as the aging of the population of the country and the slow but steady growth of the benefit roll. Similar factors are inherent in any retirement program, public or private, that has been in operation for a relatively short period. Estimates of the future cost of the old-age, survivors and disability insurance program are affected by many elements that are difficult to determine. Accordingly, the assumptions used in the actuarial cost estimates may differ widely and yet be reasonable.

The long-range cost estimates (shown for 1975 and thereafter) are presented on a range basis so as to indicate the plausible variation in future costs depending upon the actual trends developing for the various cost factors. Both the low- and high-cost estimates are based on assumptions that are intended to represent close to full employment, with average annual earnings at about the level prevailing in 1963. The use of 1963 average earnings results in conservatism in the estimate since the trend is expected to be an increase in average earnings in future years (as will be discussed subsequently in item 5). In 1963, the aggregate amount of earnings taxable under the program was \$226 billion. Of course, when new workers enter the labor force in years after 1963, the total taxable earnings increase simply because of multiplying the larger number of covered workers by the 1963 average earnings rates. In addition to the presentation of the cost estimates on a range basis, intermediate estimates developed directly from the low- and high-cost estimates (by averaging their components) are shown so as to indicate the basis for the financing provisions.

The cost estimates are extended beyond the year 2000, since the aged population itself cannot mature by then. The reason for this is that the number of births in the 1930's was very low as compared with subsequent experience. As a result, there will be a dip in the relative proportion of the aged from 1995 to about 2010, which would tend to result in low benefit costs for the old-age, survivors, and disability insurance system during that period. For this reason the year 2000 is by no means a typical ultimate year insofar as costs are concerned.

(2) Measurement of costs in relation to taxable payroll

In general, the costs are shown as percentages of covered payroll. This is the best measure of the financial cost of the program. Dollar figures taken alone are misleading. For example, a higher earnings level will increase not only the outgo of the system but also, and to

a greater extent, its income. The result is that the cost relative to payroll will decrease. As an illustration of the foregoing points, consider an individual who has covered earnings at a rate of \$300 per month. Under your committee's bill such an individual would have a primary insurance amount of \$112.40. If his earnings rate should increase by 50 percent (to \$450), his primary insurance amount would be \$145.90. Under these conditions, the contributions payable with respect to his earnings would increase by 50 percent, but his benefit rate would increase by only 30 percent. Or to put it another way, when his earnings rate was \$300 per month, his primary insurance amount represented 37.5 percent of his earnings, whereas, when his earnings increased to \$450 per month, his primary insurance amount relative to his earnings decreased to 32.4 percent.

(3) General basis for short-range cost estimates

The short-range cost estimates (shown for the individual years 1965-72) are not presented on a range basis since—assuming a continuation of present economic conditions—it is believed that the demographic factors involved (such as mortality, fertility, retirement rates, etc.) can be reasonably closely forecast, so that only a single estimate is necessary. A gradual rise in the earnings level in the future, paralleling that which has occurred in the past few years, is assumed. As a result of this assumption, contribution income is somewhat higher than if level earnings were assumed, while benefit outgo is only slightly affected.

The cost estimates have been prepared on the basis of the same assumptions and methodology as those contained in the 25th Annual Report of the Board of Trustees (H. Doc. No. 100, 89th Cong.).

(4) Level-cost concept

An important measure of long-range cost is the level-equivalent contribution rate required to support the system for the next 75 years (including not only meeting the benefit costs and administrative expenses, but also the maintenance of a reasonable contingency fund during the period, which at the end of the period amounts to 1 year's disbursements), based on discounting at interest. If such a level rate were adopted, relatively large accumulations in the old-age and survivors insurance trust fund would result, and in consequence there would be sizable eventual income from interest. Even though such a method of financing is not followed, this concept may be used as a convenient measure of long-range costs. This is a valuable cost concept, especially in comparing various possible alternative plans and provisions, since it takes into account the heavy deferred benefit costs.

(5) Future earnings assumptions

The long-range estimates for the old-age, survivors, and disability insurance program are based on level-earnings assumptions, under which earnings levels of covered workers by age and sex will continue over the next 75 years at the levels experienced in 1963. This, however, does not mean that covered payrolls are assumed to be the same each year; rather, they are assumed to rise steadily as the

population at the working ages is estimated to increase. If in the future the earnings level should be considerably above that which now prevails, and if the benefits are adjusted upward so that the annual costs relative to payroll will remain the same as now estimated for the present system, then the increased dollar outgo resulting will offset the increased dollar income. This is an important reason for considering costs relative to payroll rather than in dollars.

The long-range cost estimates have not taken into account the possibility of a rise in earnings levels, although such a rise has characterized the past history of this country. If such an assumption were used in the cost estimates, along with the unlikely assumption that the benefits, nevertheless, would not be changed, the cost relative to payroll would, of course, be lower.

It is important to note that the possibility that a rise in earnings levels will produce lower costs of the old-age, survivors, and disability insurance program in relation to payroll is a very important safety factor in the financial operations of this system. The financing of the system is based essentially on the intermediate-cost estimate, along with the assumption of level earnings; if experience follows the high-cost assumptions, additional financing will be necessary. However, if covered earnings increase in the future as in the past, the resulting reduction in the cost of the program (expressed as a percentage of taxable payroll) will more than offset the higher cost arising under experience following the high-cost estimate. If the latter condition prevails, the reduction in the relative cost of the program coming from rising earnings levels can be used to maintain the actuarial soundness of the system, and any remaining savings can be used to adjust benefits upward (to a lesser degree than the increase in the earnings level). The possibility of future increases in earnings levels should be considered only as a safety factor and not as a justification for adjusting benefits upward in anticipation of such increases.

If benefits are adjusted currently to keep pace with rising earnings trends as they occur, the year-by-year costs as a percentage of payroll would be unaffected. If benefits are increased in this manner, the level-cost of the program would be higher than now estimated, since, under such circumstances, the relative importance of the interest receipts of the trust funds would gradually diminish with the passage of time. If earnings and benefit levels do consistently rise, thorough consideration will need to be given to the financing basis of the system because then the interest receipts of the trust funds will not meet as large a proportion of the benefit costs as would be anticipated if the earnings level had not risen.

(6) *Interrelationship with railroad retirement system*

An important element affecting old-age, survivors, and disability insurance costs arose through amendments made to the Railroad

Retirement Act in 1951. These provide for a combination of railroad retirement compensation and old-age, survivors, and disability insurance covered earnings in determining benefits for those with less than 10 years of railroad service (and also for all survivor cases).

Financial interchange provisions are established so that the old-age and survivors insurance trust fund and the disability insurance trust fund are to be placed in the same financial position in which they would have been if railroad employment had always been covered under the program. It is estimated that over the long range the net effect of these provisions will be a relatively small loss to the old-age, survivors, and disability insurance system since the reimbursements from the railroad retirement system will be somewhat smaller than the net additional benefits paid on the basis of railroad earnings

(7) *Reimbursement for costs of military service wage credits*

Another important element affecting the financing of the program arose through legislation in 1956 that provided for reimbursement from general revenues for past and future expenditures in respect to the noncontributory credits that had been granted for persons in military service before 1957. The cost estimates contained here reflect the effect of these reimbursements (which are included as contributions), based on the assumption that the required appropriations will be made in the future in accordance with the relevant provisions of your committee's bill. These reimbursements would be made on the basis of constant annual amounts (although adjusted in accordance with actual experience) over the next 50 years, rather than on the basis of the actual disbursements each year, as under present law.

(d) *Actuarial balance of program in past years*

(1) *Status after enactment of 1952 act*

The actuarial balance under the 1952 act¹ was estimated, at the time of enactment, to be virtually the same as in the estimates made at the time the 1950 act was enacted, as shown in table E. This was the case, because the estimates for the 1952 act took into consideration the rise in earnings levels in the 3 years preceding the enactment of that act. This factor virtually offset the increased cost due to the benefit liberalizations made. New cost estimates made 2 years after the enactment of the 1952 act indicated that the level-cost (i.e., the average long-range cost, based on discounting at interest, relative to taxable payroll) of the benefit disbursements and administrative expenses was somewhat more than 0.5 percent of payroll higher than the level equivalent of the scheduled taxes (including allowance for interest on the existing trust fund).

¹ The term "1952 act" (and similar terms) is used to designate the system as it existed after the enactment of the amendments of that year.

TABLE E.—*Actuarial balance of old-age, survivors, and disability insurance program under various acts for various estimates, intermediate-cost basis*

[Percent]				
Legislation	Date of estimate	Level-equivalent ¹		
		Benefit costs ²	Contributions	Actuarial balance ³
	Old-age, survivors, and disability insurance ⁴			
1935 act.....	1935	5.36	5.36	
1939 act.....	1939	5.22	5.30	+0.08
1939 act (as amended in the 1940's) ⁵	1950	4.45	3.98	-.47
1950 act.....	1950	6.20	6.10	-.10
1950 act.....	1952	5.49	5.90	+ .41
1952 act.....	1952	6.00	5.90	-.10
1952 act.....	1954	6.62	6.05	-.57
1954 act.....	1954	7.50	7.12	-.38
1954 act.....	1956	7.45	7.29	-.16
1956 act.....	1956	7.85	7.72	-.13
1956 act.....	1958	8.25	7.83	-.42
1958 act.....	1958	8.76	8.52	-.24
1958 act.....	1960	8.73	8.68	-.05
1960 act.....	1960	8.98	8.68	-.30
1961 act.....	1961	9.35	9.05	-.30
1961 act.....	1963	9.33	9.02	-.31
1961 act (perpetuity basis).....	1964	9.36	9.12	-.24
1961 act (75-year basis).....	1964	9.09	9.10	+ .01
1965 bill (House).....	1965	9.44	9.36	-.08
	Old-age and survivors insurance ⁴			
1956 act.....	1956	7.43	7.23	-0.20
1956 act.....	1958	7.90	7.33	-.57
1958 act.....	1958	8.27	8.02	-.25
1958 act.....	1960	8.38	8.18	-.20
1960 act.....	1960	8.42	8.18	-.24
1961 act.....	1961	8.79	8.55	-.24
1961 act.....	1963	8.69	8.52	-.17
1961 act (perpetuity basis).....	1964	8.72	8.62	-.10
1961 act (75-year basis).....	1964	8.46	8.60	+ .14
1965 bill (House).....	1965	8.73	8.61	-.12
	Disability insurance ⁴			
1956 act.....	1956	0.42	0.49	+0.07
1956 act.....	1958	.35	.50	+ .15
1958 act.....	1958	.49	.50	+ .01
1958 act.....	1960	.35	.50	+ .15
1960 act.....	1960	.56	.50	-.06
1961 act.....	1961	.56	.50	-.06
1961 act.....	1963	.64	.50	-.14
1961 act (perpetuity basis).....	1964	.64	.50	-.14
1961 act (75-year basis).....	1964	.63	.50	-.13
1965 bill (House).....	1965	.71	.75	+ .04

¹ Expressed as a percentage of effective taxable payroll, including adjustment to reflect the lower contribution rate for the self-employed as compared with the combined employer-employee rate. Estimates prepared before 1964 are on a perpetuity basis, while those prepared after 1964 are on a 75-year basis. The estimates prepared in 1964 are on both bases (see text).

² Including adjustments (a) to reflect the lower contribution rate for the self-employed as compared with the combined employer-employee rate, (b) for the interest earnings on the existing trust fund, (c) for administrative expense costs, and (d) for the net cost of the financial interchange provisions with the railroad retirement system.

³ A negative figure indicates the extent of lack of actuarial balance. A positive figure indicates more than sufficient financing, according to the particular estimate.

⁴ The disability insurance program was inaugurated in the 1956 act so that all figures for previous legislation are for the old-age and survivors insurance program only.

⁵ The major changes being in the revision of the contribution schedule; as of the beginning of 1950, the ultimate combined employer-employee rate scheduled was only 4 percent.

NOTE.—The figures for the 1950 act and for the 1952 act according to the 1952 estimates have been revised as compared with those presented previously, so as to place them on a comparable basis with the later figures.

(2) Status after enactment of 1954 act

The 1954 amendments as passed by the House of Representatives contained an adjusted contribution schedule that not only met the increased cost of the benefit changes in the bill, but also reduced the aforementioned lack of actuarial balance to the point where, for all practical purposes, it was sufficiently provided for. The bill as it passed the Senate, however, contained several additional liberalized benefit provisions without any offsetting increase in contribution income. Accordingly, although the increased cost of the new benefit provisions was met, the "actuarial insufficiency" as then estimated for the 1952 act was left substantially unchanged under the Senate-approved bill. The benefit costs for the 1954 amendments as finally enacted fell between those of the House- and Senate-approved bills. Accordingly, under the 1954 act, the increase in the contribution schedule met all the additional cost of the benefit changes and at the same time reduced substantially the actuarial insufficiency that the then-current estimates had indicated in regard to the financing of the 1952 act.

(3) Status after enactment of 1956 act

The estimates for the 1954 act were revised in 1956 to take into account the rise in the earnings level that had occurred since 1951-52, the period that had been used for the earnings assumptions for the estimates made in 1954. Taking this factor into account reduced the lack of actuarial balance under the 1954 act to the point where, for all practical purposes, it was nonexistent. The benefit changes made by the 1956 amendments were fully financed by the increased contribution income provided. Accordingly, the actuarial balance of the system was unaffected.

Following the enactment of the 1956 legislation, new cost estimates were made to take into account the developing experience; also, certain modified assumptions were made as to anticipated future trends. In 1956-57, there were very considerable numbers of retirements from among the groups newly covered by the 1954 and 1956 amendments, so that benefit expenditures ran considerably higher than had previously been estimated. Moreover, the analyzed experience for the recent years of operation indicated that retirement rates had risen or, in other words, that the average retirement age had dropped significantly. This may have been due, in large part, to the liberalizations of the retirement test that had been made in recent years—so that aged persons were better able to effectuate a smoother transition from full employment to full retirement. The cost estimates made in early 1958 indicated that the program was out of actuarial balance by somewhat more than 0.4 percent of payroll.

(4) Status after enactment of 1958 act

The 1958 amendments recognized this situation and provided additional financing for the program—both to reduce the lack of actuarial balance and also to finance certain benefit liberalizations made. In fact, one of the stated purposes of the legislation was "to improve the actuarial status of the trust funds." This was accomplished by introducing an immediate increase (in 1959) in the combined employer-employee contribution rate, amounting to 0.5 percent, and by advancing the subsequently scheduled increases so that they would occur at 3-year intervals (beginning in 1960) instead of at 5-year intervals.

The revised cost estimates made in 1958 for the disability insurance program contained certain modified assumptions that recognized the emerging experience under the new program. As a result, the moderate actuarial surplus originally estimated was increased somewhat, and most of this was used in the 1958 amendments to finance certain benefit liberalizations, such as inclusion of supplemental benefits for certain dependents and modification of the insured status requirements.

(5) Status after enactment of 1960 act

At the beginning of 1960, the cost estimates for the old-age, survivors, and disability insurance system were reexamined and were modified in certain respects. The earnings assumption had previously been based on the 1956 level, and this was changed to reflect the 1959 level. Also, data first became available on the detailed operations of the disability provisions for 1956, which was the first full year of operation that did not involve picking up "backlog" cases. It was found that the number of persons who meet the insured status conditions to be eligible for these benefits had been significantly overestimated. It was also found that the disability incidence experience for eligible women was considerably lower than had been originally estimated, although the experience for men was very close to the intermediate estimate. Accordingly, revised assumptions were made in regard to the disability insurance portion of the program. As a result, the changes made by the 1960 amendments could, according to the revised estimates, be made without modifying the financing provisions.

(6) Status after enactment of 1961 act

The changes made by the 1961 amendments involved an increased cost that was fully met by the changes in the financing provisions (namely, an increase in the combined employer-employee contribution rate of one-fourth of 1 percent, a corresponding change in the rate for the self-employed, and an advance in the year when the ultimate rates would be effective—from 1969 to 1968). As a result, the actuarial balance of the program remained unchanged.

Subsequent to 1961, the cost estimates were further reexamined in the light of developing experience. The earnings assumption was changed to reflect the 1963 level, and the interest-rate assumption used was modified upward to reflect recent experience. At the same time, the retirement-rate assumptions were increased somewhat to reflect the experience in respect to this factor. The further developing disability experience indicated that costs for this portion of the program were significantly higher than previously estimated (because benefits are not being terminated by death or recovery as rapidly as had been originally assumed). Accordingly, the actuarial balance of the disability insurance program was shown to be in an unsatisfactory position, and this has been recognized by the Board of Trustees, who recommended that the allocation to this trust fund should be increased

(while, at the same time, correspondingly decreasing the allocation to the old-age and survivors insurance trust fund, which under present law is estimated to be in satisfactory actuarial balance even after such a reallocation).

(c) *Intermediate-cost estimates*

(1) *Purposes of intermediate-cost estimates*

The long-range intermediate-cost estimates are developed from the low- and high-cost estimates by averaging them (using the dollar estimates and developing therefrom the corresponding estimates relative to payroll). The intermediate-cost estimate does not represent the most probable estimate, since it is impossible to develop any such figures. Rather, it has been set down as a convenient and readily available single set of figures to use for comparative purposes.

The Congress, in enacting the 1950 act and subsequent legislation, was of the belief that the old-age, survivors, and disability insurance program should be on a completely self-supporting basis and actuarially sound. Therefore, a single estimate is necessary in the development of a tax schedule intended to make the system self-supporting. Any specific schedule will necessarily be somewhat different from what will actually be required to obtain exact balance between contributions and benefits. This procedure, however, does make the intention specific, even though in actual practice future changes in the tax schedule might be necessary. Likewise, exact balance cannot be obtained from a specific set of integral or rounded tax rates increasing in orderly intervals, but rather this principle of self-support should be aimed at as closely as possible.

(2) *Interest rate used in cost estimates*

The interest rate used for computing the level-costs for your committee's bill is $3\frac{1}{2}$ percent for the intermediate-cost estimate. This is somewhat above the average yield of the investments of the trust funds at the end of 1964 (about 3.13 percent), but is below the rate currently being obtained for new investments (about $4\frac{1}{8}$ percent).

(3) *Actuarial balance of OASDI system*

Table E has shown that according to the latest cost estimates made for the 1961 act there is an almost exact actuarial balance for the combined old-age, survivors, and disability insurance system, but that there is a deficit of 0.13 percent of taxable payroll for the disability insurance portion, and a favorable balance of 0.14 percent of taxable payroll for the old-age and survivors insurance portion.

Under your committee's bill, the benefit changes proposed would be approximately financed by the increases in the contribution rates and the earnings base.

Table F traces through the change in the actuarial balance of the system from its situation under the 1961 act, according to the latest estimate, to that under your committee's bill, by type of major changes involved.

TABLE F.—*Changes in actuarial balance of old-age, survivors, and disability insurance system, expressed in terms of estimated level-cost as percentage of taxable payroll, by type of change, intermediate-cost estimate, present law and committee bill, based on 3.50 percent interest*

[Percent]

Item	Old-age and survivors insurance	Disability insurance	Total system
Actuarial balance of present system.....	+0.14	-0.13	+0.01
Earnings base increase from \$4,800 to \$5,600-\$6,600.....	+ .48	+ .04	+ .52
Revised contribution schedule.....	- .03	+ .25	+ .22
Extensions of coverage.....	+ .03	-----	+ .03
7-percent benefit increase ¹	- .59	- .05	- .64
Earnings test liberalization.....	- .04	-----	- .04
Child's benefits to age 22 if in school.....	- .10	- .02	- .12
Reduced widow's benefits at age 60 ²	-----	-----	-----
Disability definition revision ³	-----	- .05	- .05
Transitional insured status for certain persons aged 72 and over.....	- .01	-----	- .01
Total effect of changes in bill.....	- .26	+ .17	- .09
Actuarial balance under bill.....	- .12	+ .04	- .08

¹ Includes also the effect of the minimum increase of \$4 in the primary insurance amount. The 7-percent increase does not apply beyond the first \$400 of average monthly wage; the same benefit factor underlying present law for average monthly wages in excess of \$110 applies for that portion of the average monthly wage above \$400.

² Includes also the cost of the provisions for paying benefits to certain divorced women.

³ Includes the provision for permitting the payment of disability benefits after the individual has first become entitled to some other benefit.

The changes made by your committee's bill would reasonably maintain the actuarial position of the old-age, survivors, and disability insurance system. The estimated favorable actuarial balance of 0.01 percent of taxable payroll for the present system would be slightly changed—to a lack of balance of 0.08 percent, which is below the established limit within which the system is considered substantially in actuarial balance.

It should be emphasized that in 1950 and in subsequent amendments, the Congress did not recommend that the system be financed by a high level tax rate in the future, but rather recommended an increasing schedule, which, of necessity, ultimately rises higher than such a level rate. Nonetheless, this graded tax schedule will produce a considerable excess of income over outgo for many years so that a sizable trust fund will develop, although not as large as would arise under an equivalent level tax rate. This fund will be invested in Government securities (just as is also the case for the trust funds of the civil service retirement, railroad retirement, national service life insurance, and U.S. Government life insurance systems). The resulting interest income will help to bear part of the higher benefit costs of the future.

(4) *Level-costs of benefits, by type*

The level-cost of the old-age and survivors insurance benefits (without considering administrative expenses and the effect of interest earnings on the existing trust fund) under the 1961 act, according to the latest intermediate-cost estimate, is about 8.51 percent of taxable payroll on the 75-year basis and the corresponding figure for the program as it would be modified by your committee's bill is 8.78 percent. The corresponding figures for the disability benefits are 0.62 percent for the 1961 act and 0.70 percent for your committee's bill.

Table G presents the benefit costs for the old-age, survivors, and disability insurance system as it would be after enactment of your committee's bill, separately for each of the various types of benefits.

TABLE G.—*Estimated level-cost of benefit payments, administrative expenses, and interest earnings on existing trust fund under the old-age, survivors, and disability insurance system, after enactment of committee bill, as percentage of taxable payroll,¹ by type of benefit, intermediate-cost estimate at 3.50 percent interest*

[Percent]		
Item	Old-age and survivors insurance	Disability insurance
Primary benefits.....	6.20	0.57
Wife's benefits.....	.50	.04
Widow's benefits.....	1.10	(2)
Parent's benefits.....	.01	(2)
Child's benefits.....	.67	.09
Mother's benefits.....	.15	(3)
Lump-sum death payments.....	.11	(2)
Total benefits.....	8.74	.70
Administrative expenses.....	.13	.03
Railroad retirement financial interchange.....	.04	.00
Interest on existing trust fund ²	— .18	.02
Net total level-cost.....	8.73	.71

¹ Including adjustment to reflect the lower contribution rate for the self-employed as compared with the combined employer-employee rate.

² This type of benefit is not payable under this program.

³ This item includes reimbursement for additional cost of noncontributory credit for military service and is taken as an offset to the benefit and administrative expense costs.

The level contribution rate equivalent to the graded schedules in the law may be computed in the same manner as level costs of benefits. These are shown in table E, as are also figures for the net actuarial balances.

(5) OASI income and outgo in near future

Under your committee's bill, old-age and survivors insurance benefit disbursements for the calendar year 1965 will be increased by about \$1.3 billion, since the effective dates for the benefit changes are January 1965 for the 7-percent benefit increase and child's benefits to age 22 while in school, and the second month after the month of enactment for most of the other changes. There will, of course, be no additional income during 1965, since the allocation rate increase and the change in the earnings base are effective on January 1, 1966.

In calendar year 1965, benefit disbursements under the old-age and survivors insurance system as modified by your committee's bill will total about \$17.0 billion. At the same time, contribution income for old-age and survivors insurance in 1965 will amount to about \$16.0 billion under your committee's bill, the same as under present law. Thus, benefit outgo under your committee's bill will exceed contribution income by about \$1.0 billion, whereas under present law, contribution income is estimated to exceed benefit outgo by about \$370 million. The size of the old-age and survivors insurance trust fund under your committee's bill will, on the basis of this estimate, decrease by about \$1.2 billion in 1965 (interest receipts are somewhat less than the outgo for administrative expenses and for transfers to the railroad retirement account); under present law, it is estimated that this trust fund would increase by about \$250 million as between the beginning and the end of 1965.

In 1966, benefit disbursements under the old-age and survivors insurance system as it would be modified by your committee's bill will be about \$18.3 billion, or an increase of about \$1.8 billion over present law. Contribution income for old-age and survivors insurance under your committee's bill for 1966 will be \$18.5 billion, or about the same as present law. Accordingly, in 1966, there will be an excess of contribution income over benefit outgo of about \$200 million under your committee's bill. There will be an excess of contributions over benefit outgo of about \$500 million in 1967 and about \$400 million in 1968.

Under the system as modified by your committee's bill, according to this estimate, the old-age and survivors insurance trust fund will be about the same size at the end of 1966 as at the beginning of the year. It will then increase by about \$240 million in 1967 and \$140 million in 1968, reaching \$18.3 billion at the end of 1968. In the next 2 years, as a result of the scheduled increase in the contribution rate in 1969, the trust fund will increase by about \$2 billion each year.

(6) DI income and outgo in near future

Under the disability insurance system, as it would be affected by your committee's bill in calendar year 1965, benefit disbursements will total about \$1,620 million, and there will be an excess of benefit disbursements over contribution income of about \$440 million. In 1966 and the years immediately following, contribution income will be well in excess of benefit outgo (as a result of the increased allocation to this trust fund, and the increased taxable earnings base, as provided by your committee's bill).

The disability insurance trust fund is estimated to decrease by about \$490 million in 1965 under your committee's bill, as compared with a corresponding decrease of about \$330 million under present law; the greater decrease results primarily from the retroactive 7-percent benefit increase. The trust fund at the end of 1966 will be about the same size as at the beginning of the year, but after 1966 it will increase in every year.

(7) Increases in benefit disbursements in 1966, by cause

The total benefit disbursements of the old-age, survivors, and disability insurance system would be increased by about \$2.1 billion in 1966 as a result of the changes that your committee's bill would make. Of this amount, about \$1.4 billion results from the 7-percent benefit increase, \$195 million from the benefit payments to children aged 18-21 who are in full-time school attendance, \$165 million from the benefit payments to widows aged 60-61, \$140 million from the liberalization of the insured-status provisions for certain persons aged 72 and over, \$105 million from the liberalization of the definition of disability, and \$65 million from the liberalization of the earnings test (the corresponding figure for this change for subsequent years will be about twice as large).

(8) Long-range operations of OASI trust fund

Table H gives the estimated operation of the old-age and survivors insurance trust fund under the program as it would be changed by your committee's bill for the long-range future, based on the intermediate-cost estimate. It will, of course, be recognized that the

figures for the next two or three decades are the most reliable (under the assumption of level-earnings trends in the future) since the populations concerned—both covered workers and beneficiaries—are already born. As the estimates proceed further into the future, there is, of course, much more uncertainty—if for no reason other than the relative difficulty in predicting future birth trends—but it is desirable and necessary nonetheless to consider these long-range possibilities under a social insurance program that is intended to operate in perpetuity.

TABLE H.—Progress of old-age and survivors insurance trust fund under system as modified by committee bill, intermediate-cost estimate at 3.50 percent interest ¹

(In millions)

Calendar year	Contributions	Benefit payments	Administrative expenses	Railroad retirement financial interchange ²	Interest on fund ¹	Balance in fund at end of year ³
Actual data						
1951.....	\$3,367	\$1,885	\$81	-----	\$417	\$15,540
1952.....	3,819	2,194	88	-----	365	17,442
1953.....	3,945	3,006	88	-----	414	18,707
1954.....	5,163	3,670	92	-\$21	447	20,576
1955.....	5,713	4,968	119	-7	454	21,663
1956.....	6,172	5,715	132	-5	526	22,519
1957.....	6,825	7,347	⁴ 162	-2	556	22,393
1958.....	7,566	8,327	⁴ 194	124	552	21,864
1959.....	8,052	9,842	184	282	532	20,141
1960.....	10,866	10,677	203	318	516	20,324
1961.....	11,285	11,862	239	332	548	19,725
1962.....	12,059	13,356	256	361	526	18,337
1963.....	14,541	14,217	281	423	521	18,480
1964.....	15,689	14,914	296	403	569	19,125
Estimated data (short-range estimate)						
1965.....	\$16,014	\$16,987	\$350	\$399	\$565	\$17,968
1966.....	18,472	18,250	375	411	546	17,950
1967.....	19,714	19,180	361	497	567	18,193
1968.....	20,325	19,943	367	466	592	18,334
1969.....	22,920	20,785	375	475	642	20,261
1970.....	24,011	21,634	383	452	740	22,543
1971.....	25,936	22,546	391	428	866	25,980
1972.....	27,186	23,392	399	408	1,026	29,993
Estimated data (long-range estimate)						
1975.....	\$28,399	\$24,440	\$390	\$307	\$1,105	\$36,829
1980.....	30,659	28,362	431	129	1,770	56,137
1990.....	35,090	36,105	510	-24	2,519	77,348
2000.....	40,701	40,407	559	-78	3,039	93,807
2025.....	50,507	61,411	769	-107	3,771	111,872

¹ An interest rate of 3.50 percent is used in determining the level-costs, but in developing the progress of the trust fund a varying rate in the early years has been used, which is equivalent to such fixed rate.

² A negative figure indicates payment to the trust fund from the railroad retirement account, and a positive figure indicates the reverse.

³ Not including amounts in the railroad retirement account to the credit of the old-age and survivors insurance trust fund. In millions of dollars, these amounted to \$377 for 1953, \$284 for 1954, \$163 for 1955, \$60 for 1956, and nothing for 1957 and thereafter.

⁴ These figures are artificially high because of the method of reimbursements between this trust fund and the disability insurance trust fund (and, likewise, the figure for 1959 is too low).

NOTE.—Contributions include reimbursement for additional cost of noncontributory credit for military service.

In every year after 1965 for the next 20 years, contribution income under the system as it would be modified by your committee's bill is estimated to exceed old-age and survivors insurance benefit disburse-

ments. Even after the benefit-outgo curve rises ahead of the contribution-income curve, the trust fund will nonetheless continue to increase because of the effect of interest earnings (which more than meet the administrative expense disbursements and any financial interchanges with the railroad retirement program). As a result, this trust fund is estimated to grow steadily under the long-range cost estimate (with a level-earnings assumption), reaching \$36 billion in 1975, \$56 billion in 1980, and over \$90 billion at the end of this century. In the very far distant future, namely, in about the year 2015, the trust fund is estimated to reach a maximum of about \$150 billion.

(9) *Long-range operations of DI trust fund*

The disability insurance trust fund, under the program as it would be changed by your committee's bill, grows slowly but steadily after 1966, according to the intermediate long-range cost estimate, as shown by table I. In 1975, it is shown as being \$3.5 billion, while in 1990, the corresponding figure is \$9.3 billion. There is a small excess of contribution income over benefit disbursements for every year after 1965.

TABLE I.—Progress of disability insurance trust fund under system as modified by committee bill, intermediate-cost estimate at 3.50 percent interest ¹

[In millions]						
Calendar year	Contributions	Benefit payments	Administrative expenses	Railroad retirement financial interchange ²	Interest on fund ¹	Balance in fund at end of year
Actual data						
1957.....	\$702	\$57	³ \$3	-----	\$7	\$649
1958.....	966	249	³ 12	-----	25	1,379
1959.....	891	457	50	—\$22	40	1,825
1960.....	1,010	568	36	—5	53	2,289
1961.....	1,038	887	64	5	66	2,437
1962.....	1,046	1,105	66	11	68	2,368
1963.....	1,099	1,210	68	20	66	2,235
1964.....	1,154	1,309	79	19	64	2,047
Estimated data (short-range estimate)						
1965.....	\$1,187	\$1,624	\$85	\$20	\$50	\$1,555
1966.....	1,840	1,784	110	20	46	1,527
1967.....	2,044	1,880	119	20	46	1,598
1968.....	2,109	1,959	124	15	47	1,656
1969.....	2,177	2,017	128	15	50	1,723
1970.....	2,246	2,069	132	15	53	1,806
1971.....	2,426	2,126	135	15	58	2,014
1972.....	2,543	2,174	139	15	67	2,296
Estimated data (long-range estimate)						
1975.....	\$2,412	\$2,146	\$103	—\$3	\$109	\$3,502
1980.....	2,604	2,346	106	—11	159	5,014
1990.....	2,980	2,630	107	—14	300	9,270
2000.....	3,456	3,096	120	—14	541	16,442
2025.....	4,289	4,230	156	—14	1,237	36,958

¹ An interest rate of 3.50 percent is used in determining the level-costs, but in developing the progress of the trust fund a varying rate in the early years has been used, which is equivalent to such fixed rate.

² A negative figure indicates payment to the trust fund from the railroad retirement account, and a positive figure indicates the reverse.

³ These figures are artificially low because of the method of reimbursements between the trust fund and the old-age and survivors insurance trust fund (and, likewise, the figure for 1959 is too high).

NOTE.—Contributions include reimbursement for additional cost of noncontributory credit for military service.

(f) *Cost estimates on range basis*(1) *Long-range operations of trust funds*

Table J shows the estimated operation of the old-age and survivors insurance trust fund under the program as it would be changed by your committee's bill for low- and high-cost estimates, while table K gives corresponding figures for the disability insurance trust fund.

Under the low-cost estimate, the old-age and survivors insurance trust fund builds up quite rapidly and in the year 2000 is shown as being about \$260 billion and is then growing at a rate of about \$16 billion a year. Likewise, the disability insurance trust fund grows steadily under the low-cost estimate, reaching about \$9 billion in 1980 and \$38 billion in the year 2000, at which time its annual rate of growth is about \$2 billion. For both trust funds, under these estimates, benefit disbursements do not exceed contribution income in any year after 1965 for the foreseeable future.

TABLE J.—*Estimated progress of old-age and survivors insurance trust fund under system as modified by committee bill, low- and high-cost estimates*

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Railroad retirement financial inter-change ¹	Interest on fund ²	Balance in fund at end of year
Low-cost estimate						
1975.....	\$29,035	\$23,966	\$361	\$287	\$1,513	\$46,828
1980.....	31,621	27,538	399	104	2,625	77,292
1990.....	37,422	34,376	469	-54	5,101	145,892
2000.....	44,618	37,871	515	-113	9,178	260,377
High-cost estimate						
1975.....	\$27,789	\$24,915	\$418	\$327	\$780	\$27,126
1980.....	29,691	29,186	464	154	1,069	35,932
1990.....	32,753	37,834	550	6	363	12,504
2000.....	36,780	42,943	603	-43	(³)	(³)

¹ A negative figure indicates payment to the trust fund from the railroad retirement account, and a positive figure indicates the reverse.

² At interest rates of 3.75 percent for the low-cost estimate and 3.25 percent for the high-cost estimate.

³ Fund exhausted in 1993.

NOTE.—Contributions include reimbursement for additional cost of noncontributory credit for military service.

TABLE K.—*Estimated progress of disability insurance trust fund under system as modified by committee bill, low- and high-cost estimates*

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Railroad retirement financial inter-change ¹	Interest on fund ²	Balance in fund at end of year
Low-cost estimate						
1975.....	\$2,463	\$2,001	\$94	—\$6	\$195	\$5,765
1980.....	2,685	2,174	95	—15	314	9,124
1990.....	3,177	2,428	94	—19	689	19,651
2000.....	3,788	2,899	103	—19	1,337	37,684
High-cost estimate						
1975.....	\$2,361	\$2,291	\$112	-----	\$37	\$1,294
1980.....	2,522	2,517	117	—\$7	28	1,054
1990.....	2,782	2,832	120	—9	(³)	(³)
2000.....	3,124	3,293	137	—9	(³)	(³)

¹ A negative figure indicates payment to the trust fund from the railroad retirement account, and a positive figure indicates the reverse.

² At interest rates of 3.75 percent for the low-cost estimate and 3.25 percent for the high-cost estimate.

³ Fund exhausted in 1988.

NOTE.—Contributions include reimbursement for additional cost of noncontributory credit for military service.

On the other hand, under the high-cost estimate the old-age and survivors insurance trust fund builds up to a maximum of about \$36 billion in about 15 years, but decreases thereafter until it is exhausted shortly before the year 2000. Under this estimate, benefit disbursements from the old-age and survivors insurance trust fund are lower than contribution income during all years after 1965 and before 1981.

As to the disability insurance trust fund, under the high-cost estimate, in the early years of operation the contribution income is about the same as the benefit outgo. Accordingly, the disability insurance trust fund, as shown by this estimate, will be about \$1.5 billion during the first few years after 1965 and will then slowly decrease until it is exhausted in 1988.

The foregoing results are consistent and reasonable, since the system on an intermediate-cost-estimate basis is intended to be approximately self-supporting, as indicated previously. Accordingly, a low-cost estimate should show that the system is more than self-supporting, whereas a high-cost estimate should show that a deficiency would arise later on. In actual practice, under the philosophy in the 1950 and subsequent acts, as set forth in the committee reports therefor, the tax schedule would be adjusted in future years so that none of the developments of the trust funds shown in tables J and K would ever eventuate. Thus, if experience followed the low-cost estimate, and if the benefit provisions were not changed, the contribution rates would probably be adjusted downward—or perhaps would not be increased in future years according to schedule. On the other hand, if the experience followed the high-cost estimate, the contribution rates would have to be raised above those scheduled. At any rate, the high-cost estimate does indicate that, under the tax schedule adopted, there will be ample funds to meet benefit disbursements for several decades, even under relatively high-cost experience.

(2) *Benefit costs in future years relative to taxable payroll*

Table L shows the estimated costs of the old-age and survivors insurance benefits and of the disability insurance benefits under the program as it would be changed by your committee's bill as a percentage of taxable payroll for various future years, through the year 2040, and also the level-costs of the two programs for the low-, high-, and intermediate-cost estimates (as was previously shown in tables E and G for the intermediate-cost estimate).

TABLE L.—*Estimated cost of benefits of old-age, survivors, and disability insurance system as percent of taxable payroll,¹ under system as modified by committee bill*

[In percent]

Calendar year	Low-cost estimate	High-cost estimate	Intermediate-cost estimate ²
Old-age and survivors insurance benefits			
1975.....	7.33	7.95	7.64
1980.....	7.72	8.70	8.20
1990.....	8.14	10.24	9.12
2000.....	7.52	10.35	8.80
2025.....	8.65	13.78	10.76
2040.....	9.81	14.81	11.78
Level-cost ³	7.64	10.13	8.73
Disability insurance benefits			
1975.....	0.61	0.73	0.67
1980.....	.61	.75	.68
1990.....	.57	.77	.66
2000.....	.57	.79	.67
2025.....	.65	.86	.74
2040.....	.70	.91	.78
Level-cost ³.....	.64	.82	.71

¹ Taking into account the lower contribution rate for the self-employed, as compared with the combined employer-employee rate.

² Based on the averages of the dollar contributions and dollar costs under the low-cost and high-cost estimates.

³ Level contribution rate, at an interest rate of 3.25 percent for high-cost, 3.50 percent for intermediate-cost, and 3.75 percent for low-cost, for benefits after 1964, taking into account interest on the trust fund on December 31, 1964, future administrative expenses, the railroad retirement financial interchange provisions, the reimbursement of military-wage-credits cost, and the lower contribution rates payable by the self-employed.

Your committee believes that it would be desirable to amortize the amounts owing over a period longer than the 10-year period provided under present law. The bill would authorize a level annual appropriation from general revenues to the trust funds, starting in fiscal year 1966, that would amortize both the accumulated backlog and the additional amounts that will accrue through fiscal year 2015. After 2015, annual appropriations would be authorized to pay any additional costs.

E. GENERAL DISCUSSION OF PUBLIC ASSISTANCE AMENDMENTS

1. INCREASED FEDERAL PAYMENTS UNDER PUBLIC ASSISTANCE TITLES

Your committee's bill provides for an increase in the payments to public assistance recipients, effective January 1, 1966. The formula determining the Federal share of assistance payments is liberalized by increasing the Federal proportion of the payments in the first step of the formula and by raising the ceiling on Federal sharing in the

second step of the formula. For the adult categories—OAA, APTD, AB, and for the combined program for the aged, blind, and disabled—the formula is changed from twenty-nine thirty-fifths of the first \$35 of the average assistance payment to thirty-one thirty-sevenths of the first \$37 of the average assistance payment. The ceiling is raised on the average payments from \$70 a month to \$75 a month. The provisions in the formula under titles I and XVI adding \$15 to the ceiling for vendor medical care payments in which there can be Federal participation and otherwise recognizing medical payments are not affected by this formula change, except that the steps of the statutory formula are rearranged to improve their equitable application.

For the program of AFDC, the formula change made in your committee's bill would be from fourteen-seventeenths of the first \$17 of the average payment per recipient to five-sixths of the first \$18 of the average assistance payment. The ceiling is raised from \$30 a month to \$32 a month. Under your committee's bill, there would be an increase in Federal payments averaging about \$2.50 a month for the needy recipients in the adult assistance categories and an increase of about \$1.25 a month for the needy children and the adults caring for them. The level of aid provided the needy justifies this modest increase.

2. REMOVAL OF LIMITATIONS ON FEDERAL PARTICIPATION IN ASSISTANCE TO AGED INDIVIDUALS WITH TUBERCULOSIS OR MENTAL DISEASES

Since the enactment of the Social Security Act, patients in public mental and tuberculosis hospitals have not been eligible under the public assistance titles of the Social Security Act, and only prior to 1951 were individuals eligible who were patients in private mental and tuberculosis hospitals. The reason for this exclusion was that long-term care in such hospitals had generally been accepted as a responsibility of the States. In the opinion of your committee, contemporary developments in the treatment of mental disorders and tuberculosis justify a new approach to the problem of the care of the aged who have these diseases. A partial recognition of this change in the treatment of the mentally ill and the tuberculous was made in 1960, when this committee recommended and the Congress acted to permit Federal participation in the cost of medical payments for aged persons diagnosed as psychotic or tubercular when they are in general medical hospitals because of such diagnosis, for up to 42 days. Although this amendment has proved useful, your committee believes a more fundamental change in the Federal law is needed if new treatment methods are to be more widely used in the Nation.

There have been many encouraging developments in the care and treatment of the mentally ill and the tuberculous. Most significantly progress is being made in the provision of short-term therapy in the patient's own home, in special sections of general hospitals, in specialized mental hospitals, and in community mental health centers. This latter type of facility is being particularly encouraged by Federal help under the Community Mental Health Centers Act of 1963.

With the progress in development of short-term therapy for the mentally ill and the tuberculous, your committee believes that the distinction hitherto maintained in the public assistance titles of the Social Security Act—between the aged who are ill with a diagnosis of

psychosis or tuberculosis and the aged with other diagnosed illnesses is no longer necessary or desirable. Your committee is convinced that the entire mental health program of the States can be advanced and the care of the mentally ill aged can be materially improved by the elimination of the distinction in the Federal law between disease classifications. Thus, under the provisions of your committee bill, Federal financial participation would become available effective January 1, 1966, in assistance (money payments, if appropriate, or payment for medical care) for aged persons otherwise eligible under State plans for OAA, MAA, or under the combined programs for the aged, blind or disabled who: (1) are patients in hospitals for mental diseases or for tuberculosis or (2) are patients in general hospitals without regard to the length of their stay, who are there because of a diagnosis of psychosis or tuberculosis. Federal financial participation would also become available for assistance under titles X, XIV, and XVI of the Social Security Act for blind or disabled persons of any age who are in a general hospital with a diagnosis of psychosis or tuberculosis.

Since the provisions of the bill are designed to improve the care provided by States and to assure that Federal participation is used for such improvement, it is not intended that the availability of care for the mentally ill or tubercular under other State or local programs be considered a resource in determining the eligibility of patients for public assistance with Federal participation in the payments made.

Your committee is concerned that certain safeguards and standards are maintained. These safeguards are to be included in the plans of States which wish to take advantage of these provisions for the provision of assistance to or in behalf of patients in mental or tuberculosis hospitals. Your committee believes that the closest collaboration in the planning and execution of the plans will be needed by the State welfare agencies and the State agencies responsible for the programs for the mentally ill and the tuberculous. Your committee's bill is intended to broaden the resources available to the community (including the public welfare agencies) in planning for the needy aged who have these diseases. For this reason, your committee has included in its bill a provision for a joint agreement or other arrangement between the units of State or (where appropriate) local governments, and where appropriate with institutions for mental diseases or tuberculosis. This agreement is not only intended to set forth the way of work between the agencies administering welfare and health programs, but also to set forth alternative methods of care, particularly for the aged who are mentally ill. Institutional treatment and care in the individual's own home are only two of the possible ways of caring for the aged who have mental problems. It is expected that the joint agreements will include plans for the use of other methods of care, such as nursing homes, short-term care in general hospitals, foster family care, and others. This legislation, it is anticipated, will give further encouragement to the trend in the States for discharging from mental hospitals to the community the aged who are considered able to care for themselves, under some form of protective arrangements. Your committee is aware that not always does a discharge plan work out to the best advantage of the patient, and thus your committee's bill provides that the agreement must make provision for the prompt readmittance to the institution where needed for

the aged person who had been placed under alternate plans of care. Inasmuch as the public welfare agency will be responsible for the determination of eligibility under the State plan for all applicants for assistance in the hospital, it is important that representatives of the agency have free access to the patient in the hospital. It is equally important that the hospital give to the public welfare agency the information it needs to administer its part of the program including the provision of assistance and the related social services. Under your committee bill, the agreement must include these arrangements.

A second safeguard, under your committee's bill, is a provision that the State plan include a provision for an individual plan for each patient in the hospital to assure that the care provided to him is in his best interests and that there will be initial and periodic review of his medical and other needs. Your committee is particularly concerned that the patient receive care and treatment designed to meet his particular needs. Thus, under your committee bill, the State plan would also need to assure that the medical care needed by the patient will be provided him and that other needs considered essential will be met and that there will be periodic redetermination of the need for the individual to be in the hospital.

Your committee bill provides for the development in the State of alternative methods of care and requires that the maximum use be made of the existing resources in the community which offer ways of caring for the mentally ill who are not in hospitals. This is intended to include provision for persons who no longer need care in hospitals and who can, with financial help and social services to the extent needed, make their way in the community. Under the 1962 public welfare amendments, State public welfare agencies are encouraged to provide social services for the aged and additional Federal financing is available to assist in the cost. Under your committee bill, these social services would be made available, as appropriate, for the aged who are in the hospitals or who would otherwise need care in an institution.

Your committee believes that responsibility for the treatment of persons in mental hospitals—whether or not they be assistance recipients—is that of the mental health agency of the State. Social services may be needed for members of the patient's family, and this responsibility can be carried by the local welfare agency with Federal financial help. When the patient leaves the mental hospital to receive one of the alternative methods of care, followup social services are usually essential if the discharge plan is to be successful. Such services can be given by the public welfare agency or (if provided in the agreement between the two agencies referred to earlier) could be given by the staff of the hospital. Social services to the aged who have mental health problems, your committee believes, are important as a means of preventing further deterioration and avoiding or delaying admittance or readmittance to the institution.

Your committee recognizes that the administration of these provisions will place new responsibilities upon the welfare agencies and if these responsibilities are to be carried out effectively, appropriate planning and execution will be required. Thus your committee's bill provides authority for the Secretary to establish necessary methods of administration for the States in carrying out these provisions.

Under the bill, the Federal Government will be participating in the costs of care given to the needy aged in certain institutions. In

order to assure that the rates for the care of recipients who are patients in such institutions are reasonable, the bill provides that the State must have suitable methods for the determination of the cost. Your committee expects that this determination will be made without imposing burdensome fiscal methods on the States.

Your committee believes it is important that States move ahead promptly to develop comprehensive mental health plans as contemplated in the Community Mental Health Centers Act of 1963. In order to make certain that the planning required by your committee's bill will become a part of the overall State mental health planning under the Community Mental Health Centers Act of 1963, your committee's bill makes the approvability of a State's plan for assistance for individuals in mental and tuberculosis hospitals dependent upon a showing of satisfactory progress toward developing and implementing a comprehensive mental health program—including utilization of community mental health centers, nursing homes, and other alternative forms of care.

Your committee wishes to insure that the additional Federal funds to be made available to the States under the provisions of the bill will assist the overall improvement of mental health services in the State. State and local funds now being used for institutional care of the aged will be released as a result of the bill, but there is great need for increased professional services in hospitals and for development of alternate methods of care outside the hospitals. To accomplish this, States may have to reallocate their expenditures for mental health to promote new methods of treatment and care. Your committee bill provides that the States will receive additional Federal funds only to the extent that a showing is made to the satisfaction of the Secretary that total expenditures of the States or its political subdivisions from their own funds for mental health services are increased. Such expenditures may be financed under State or local public health or public welfare programs. Expenditures will be measured against a base period and will include comparable items of expenditure for mental health programs by State and local public health and welfare agencies, including expenditures for payments to or in behalf of public assistance recipients with mental health problems and expenditures for services and other administrative items under health and welfare programs.

3. PROTECTIVE PAYMENTS

Your committee has been concerned about the problems of our aged citizens who have marginal capacity to handle their own affairs. Old-age assistance recipients are among those with the most serious problems, both because of their advanced age (average age is 76) and because they have so little resources that the usual guardianship services under State law may not be available. States may now, with Federal participation, use guardians as payees for public assistance payments, or under section 1111 of the Social Security Act, enacted in 1958, may use a special legal representative as the payee. Your committee has been advised that these arrangements still do not offer enough flexibility to meet all the needs that arise and thus, the bill contains additional provisions.

Under your committee's bill, States with Federal financial participation may make a protective payment to a third party, someone with

an interest or concern for the individual recipient. This provision is similar to the protective payment provision included in the AFDC program as one part of the 1962 Public Welfare Amendments. It would be effective January 1, 1966, and would be applicable to recipients of money payments under title I or title XVI.

Your committee is aware of the serious nature of a decision not to give a needy person the money which he would ordinarily receive directly, but instead to pay it in his behalf to a third party. Your committee's bill, therefore, has several safeguards to protect the individual's rights. For Federal sharing to be claimed in such payments, the State plan, under the bill, would have to show that a determination will be made that such individual has, by reason of his physical or mental condition, such inability to manage his own money that making payments directly to him would not be in his best interests. Furthermore, States would be able to make payments with Federal sharing only when the payments meet all the need, as determined under the State plan, of the individual. This safeguard was included by your committee because some States do not meet need according to their own standards and thus it is possible that the difficulty ascribed to the individual in handling his money may be due to the inadequate assistance he is receiving.

The State plan would have to show, in addition, that the State is undertaking and continuing efforts to protect the welfare of the individual and to the extent possible, improve his capacity for self-care and to handle his money. To avoid the possibility of protective payment arrangements continuing beyond the period necessary, the bill provides, further, that the State agency will need to make periodic reviews to determine whether conditions justify the continuation of the arrangement and if they do not, for direct payments to be resumed, or if the conditions warrant, for the judicial appointment of a guardian or a legal representative as authorized by section 1111 of the Social Security Act. The bill also provides specifically that the State agency must offer to the individual affected, if he is dissatisfied, an opportunity for a fair hearing on the decision to make his payment to a third party.

4. DISREGARDING CERTAIN EARNINGS IN DETERMINING NEED UNDER OLD-AGE ASSISTANCE AND COMBINED PROGRAMS

Your committee's bill provides for a modest increase in the amount of earnings States may disregard in determining need under the program of OAA and for the aged receiving assistance under the combined program for the aged, blind, and disabled. Currently, States may disregard no more than the first \$10 a month, and one-half of the remainder within a total of \$50 per month of earned income. The bill would raise those amounts to \$20 a month and one-half of the remainder within a total of \$80 per month of earned income, effective January 1, 1966.

Your committee is convinced that it is sound for the aged to continue in employment as long as they can, and that those who work should have some incentive and special consideration. Currently 23 States have implemented the earlier legislation and are disregarding some earned income of the aged. This amendment will permit these

States, and others which have not yet acted, to implement the legislation to increase the amounts disregarded.

5. ADMINISTRATIVE AND JUDICIAL REVIEW OF CERTAIN ADMINISTRATIVE DETERMINATIONS

Your committee bill contains new provisions effective January 1, 1966 for administrative and judicial review of certain administrative determinations under titles I, IV, X, XIV, XVI, and XIX of the Social Security Act. These provisions are designed to assure that the States will not encounter undue delays in obtaining Federal determinations on acceptability of proposed State plan material under the public assistance programs, and that the States will be able to obtain judicial review of their plan proposals at an appropriate stage of the proceedings. These provisions are not intended to affect adversely the usual negotiation process between the Department of Health, Education, and Welfare and the States which, in nearly all instances, results in the development of a State plan or plan amendment that can be approved by the Secretary.

When a State submits a new plan under one of the public assistance titles, the Secretary shall make a determination within 90 days as to whether the proposal meets the applicable requirements for approval. This period may be extended by written agreement of the Secretary and the State. If the State is dissatisfied with the Secretary's determination, it may, within 60 days, petition for a reconsideration. The Secretary shall then set a time and place for a hearing, to begin from 20 to 60 days after the date notice of the hearing is furnished to the State, unless the Secretary and the State agree in writing upon another time. Within 60 days of the conclusion of the hearing, the Secretary shall affirm, modify, or reverse his original determinations. If the State is dissatisfied with this final determination, it may, within 60 days, appeal to the U.S. court of appeals. In the judicial proceeding, the findings of fact by the Secretary shall be conclusive, unless substantially contrary to the weight of the evidence; if good cause is shown for taking further evidence, the court may remand the case to the Secretary for this purpose. The court may affirm the action of the Secretary or set it aside, in whole or in part. The court's judgment shall be subject to review by the Supreme Court of the United States upon certiorari or certification.

The foregoing procedures are also applicable, at the option of the State, upon submittal of any amendment of an approved State plan.

The bill does not amend sections 4, 404, 1004, 1404, 1604, or 1904 of the Social Security Act, which provide that the Secretary shall give reasonable notice and opportunity for hearing to a State prior to discontinuing payments under a previously approved State plan because of his finding that the plan has been so changed that it no longer complies with certain requirements or that in the administration of the plan there is a failure to comply substantially with certain requirements. However, the bill provides that upon any such final determination by the Secretary, the State may appeal to the U.S. court of appeals, in the same way as described above for appeals from a final determination of the Secretary in connection with submittal of a new plan.

The bill further provides that action pursuant to an initial deter-

mination of the Secretary, as therein described, shall not be stayed pending reconsideration. If the Secretary subsequently determines that his initial determination was incorrect, he shall pay forthwith in a lump sum any amounts, not otherwise already paid, which are payable to the State in accordance with the corrected determination of the Secretary on the basis of the expenditures made by the State.

In addition to questions concerning State plan proposals, or which involve discontinuance of Federal payments under part or all of a State plan, disagreements between a State and the Secretary may occur when the Secretary disallows specific State expenditures for Federal financial participation. Such disallowances usually take the form of audit exceptions. The bill provides that whenever the Secretary determines that there shall be a disallowance the State shall be entitled, on request, to an administrative reconsideration of the decision.

6. MAINTENANCE OF STATE EFFORT

Under various provisions of this bill, additional Federal funds will be available to States to improve the public assistance program. Your committee has recognized the need for such program improvement in medical care, in basic maintenance, as well as in other areas, and believes that the Federal funds designated for these purposes should be used by the States for these purposes and not as a substitute for State funds. For this reason, the bill incorporates a provision which assures that the additional Federal funds made available to States are used within the public assistance program. Additional Federal funds will, under these provisions, be granted to States only to the extent that existing State expenditures in the program are maintained. For a period beginning January 1, 1966, and ending June 30, 1969, a measurement of these expenditures will be made in the process of granting the Federal funds to the States. Your committee believes that after June 30, 1969, the new funds will be so integrated into the programs of the States that further testing of this fact will not be needed.

Under the bill, expenditures from total and Federal funds for a particular quarter are compared with total and Federal expenditures in a "base period," either the corresponding quarter or an average of the quarters in the fiscal year ending June 30, 1964, or June 30, 1965. If this comparison shows that the increase in Federal funds as computed under the revised formula exceeds the increase in total expenditures, the increase in Federal share must be reduced to the amount of the increase in total expenditures between the base period and the quarter in question. The purpose of this provision is to assure that whatever additional Federal funds are made available to the States

under the revised formulas for computing the Federal share and under provisions for program expansion will be used for program improvements and that no part of any additional Federal funds will be used to replace non-Federal funds.

7. DISREGARDING SO MUCH OF OASDI BENEFIT INCREASE AS IS ATTRIBUTABLE TO RETROACTIVE EFFECTIVE DATE

Under title III of the bill, beneficiaries of the OASDI program will receive a 7-percent increase in their benefits retroactively effective to January 1, 1965. These benefits will be payable to beneficiaries in a lump-sum check in addition to the regular monthly check. There are currently many thousands of such beneficiaries who are receiving supplementary assistance from various of the public assistance programs under provisions of the Social Security Act. Moreover, certain children over 18 and in school will receive benefits from January 1, 1965. Your committee believes that it would be appropriate for the State public assistance agencies to disregard these retroactive payments as one-time-only income, not significant in amount and not income which under various other longstanding provisions of the public assistance titles to the act must be taken into account by the State in determining the amount of assistance for the individual.

The bill adds a provision to make it clear that States need not take these sums into consideration in determining the need of the public assistance recipients who also receive an OASDI benefit.

8. AMENDMENT TO DEFINITION OF MEDICAL ASSISTANCE FOR THE AGED

When the MAA program was enacted in 1960, the law prohibited Federal sharing in MAA payments made in behalf of an aged person receiving OAA in the month MAA services were received. This provision has proved to be a hardship in the planning of States for the necessary movement of ill aged persons to and from medical institutions such as nursing homes and hospitals. For the month of movement to or from such a medical facility, States are faced with a heavy expenditure of funds, only part of which, under current provisions of law, is subject to Federal sharing. A State which has made an OAA payment to a needy person to cover his expenses in his own home is unable to claim any Federal funds as MAA when the individual goes to a medical institution that month. The reverse situation arises when the individual leaves the medical institution in which services are received under MAA.

In order to meet this need, the bill would relax the prohibition on Federal sharing in OAA and MAA for the same month so as to permit such sharing effective July 1, 1965, for MAA services furnished in the month an individual enters or leaves a medical facility.

9. EXTENSION OF GRACE PERIOD FOR DISREGARDING CERTAIN INCOME FOR STATES WHERE LEGISLATURE HAS NOT MET IN REGULAR SESSION

Section 701 of the Economic Opportunity Act of 1964 provides that certain amounts of income of an individual derived from titles I and II of that act may not be taken into account by State public assistance agencies in determining the need of such individual or any other individual for public assistance under programs authorized by the Social Security Act. The purpose of this amendment was to provide an incentive for persons who are beneficiaries of programs under the Economic Opportunity Act to undertake training and employment by permitting public assistance payments to continue for them and their families, if they are otherwise eligible, and not be reduced by specified amounts of their income under such programs. The statute provides that States with a legislative impediment to putting this provision into effect shall have until July 1, 1965, to obtain the necessary legislative change. A problem has arisen in the instance of States which do not have a regular meeting of their legislature until 1966 to make the necessary changes to State law. Under this section of the bill, such States would have until the first month following the month of adjournment of a State's first regular legislative session adjourning after the date of enactment of the Economic Opportunity Act of 1964 to act.

10. TECHNICAL AMENDMENTS TO ELIMINATE PUBLIC ASSISTANCE PROVISIONS WHICH BECOME OBSOLETE IN 1967

Title XIX, to be added to the Social Security Act by title I of this bill, would, effective July 1, 1967, provide the sole statutory base for States to receive Federal funds for the provision of payments for vendor medical care in behalf of the needy. On that date, Federal financial participation in vendor payments for medical care will not be possible under other of the public assistance titles of the act. Thus, on July 1, 1967, numerous provisions of the various public assistance titles become inoperative. The bill identifies those provisions and appropriately repeals or amends them as of July 1, 1967.

11. COSTS OF INCREASES IN THE PUBLIC ASSISTANCE MATCHING FORMULAS

The accompanying table shows by State and by assistance programs the additional amounts of money that will be available to States under the changes in public assistance formulas made by title IV. These total almost \$150 million for the first full year, or \$75 million for the 6 months of the fiscal year ending June 30, 1966, that they would be effective. Like other increases in public assistance provided by the bill, the States would receive these amounts only to the extent that they made corresponding increases in their total expenditures.

Public assistance: Estimated annual increase in Federal funds under proposal to raise Federal participation in assistance payments to specified levels¹

[In thousands]

States and District of Columbia	Total all programs	Old-age assistance	Aid to the blind	Aid to the permanently and totally disabled	Aid to the aged, blind, and disabled (title XVI)	Aid to families with dependent children
Total.....	\$148,520	\$50,953	\$2,352	\$10,194	\$22,117	\$62,904
Alabama.....	3,817	2,640	42	346		789
Alaska.....	154	(²)	(³)	(²)	69	85
Arizona.....	933	319	38	68		508
Arkansas.....	2,012	1,392	47	221		352
California.....	22,919	11,495	523	2,008		8,893
Colorado.....	2,731	³ 1,735	11	253		732
Connecticut.....	1,543	321	13	172		1,037
Delaware.....	203	32	13	18		140
District of Columbia.....	581	100	8	130		343
Florida.....	3,354	(²)	(²)	(²)	2,167	1,187
Georgia.....	3,691	2,206	76	624		785
Hawaii.....	344	(²)	(²)	(²)	97	247
Idaho.....	494	220	6	67		201
Illinois.....	8,543	(²)	(²)	(²)	3,751	4,792
Indiana.....	1,260	557	76	45		582
Iowa.....	2,172	1,286	54	50		782
Kansas.....	1,829	(²)	(²)	(²)	1,201	628
Kentucky.....	2,620	(²)	(²)	(²)	1,682	938
Louisiana.....	4,992	3,186	134	452		1,220
Maine.....	568	(²)	(²)	(²)	329	239
Maryland.....	1,791	(²)	(²)	(²)	519	1,272
Massachusetts.....	4,497	2,295	96	494		1,612
Michigan.....	5,308	(²)	(²)	(²)	2,481	2,827
Minnesota.....	2,008	³ 988	48	82		890
Mississippi.....	2,874	1,782	71	415		606
Missouri.....	4,288	2,459	164	351		1,284
Montana.....	456	249	11	58		138
Nebraska.....	968	553	29	108		278
Nevada.....	199	107	7	(⁴)		85
New Hampshire.....	315	196	12	25		82
New Jersey.....	2,510	335	40	349		1,786
New Mexico.....	950	(²)	(²)	(²)	331	619
New York.....	12,844	(²)	(²)	(²)	3,977	8,867
North Carolina.....	3,099	1,047	122	523		1,407
North Dakota.....	476	(²)	(²)	(²)	330	146
Ohio.....	6,860	2,873	141	786		3,060
Oklahoma.....	6,115	(²)	(²)	(²)	4,650	1,465
Oregon.....	1,036	269	18	187		562
Pennsylvania.....	6,484	1,937	216	471		3,860
Rhode Island.....	802	(²)	(²)	(²)	374	428
South Carolina.....	1,228	629	43	205		351
South Dakota.....	404	174	3	26		201
Tennessee.....	2,373	1,099	53	301		920
Texas.....	6,899	5,504	116	221		1,058
Utah.....	647	122	8	114		403
Vermont.....	224	(²)	(²)	(²)	159	65
Virginia.....	1,058	322	28	161		547
Washington.....	2,540	812	28	437		1,263
West Virginia.....	1,978	352	20	148		1,458
Wisconsin.....	2,375	1,266	35	252		822
Wyoming.....	154	64	2	26		62

¹ For OAA, AB, APTD, and AABD (title XVI), raise 29/35 of \$35 to 31/37 of \$37; and for AFDC, from 14/17 of \$17 to 5/6 of \$18; raise maximum average monthly payment from \$70 to \$75; and for AFDC, from \$30 to \$32. Assumes that States will continue to spend the same amount per recipient from State and local funds as in May 1964, and that the increase in Federal funds will be used to raise money payments to recipients.

² Combined under aid to the aged, blind, and disabled.

³ Based on State's estimate of the number of recipients and average payment for September 1964, which shows transfers from OAA to MAA, not reflected in May data.

⁴ No program for APTD.

Summary—Cost of public assistance and related items

[In millions of dollars]

Costs	Fiscal year 1965	Annual rate
Title I, pt. 2: Medical assistance	100	200
Title II:		
Pt. 1: Maternal and child health, crippled children	25	60
Pt. 2: Mental retardation projects	2.75	2.75
Pt. 3: Mental and tuberculosis	38	75
Pt. 3: Medical assistance for the aged definition	2	2
Title IV:		
Formula changes	75	150
Protective payments	(1)	(1)
Income exemption (old-age assistance) .....	.5	1
Total	243.25	490.75

¹ No cost.

F. MEDICAL EXPENSE DEDUCTIONS FOR INCOME TAX PURPOSES

1. PRESENT LAW

As a general rule under the Internal Revenue Code only that portion of the medical care expenses paid by the taxpayer for himself, his spouse, or his dependents which exceeds 3 percent of adjusted gross income may be deducted. Included in the category of deductible medical expenses subject to this 3-percent floor are premiums paid for accident and health insurance. In computing medical care expenses for the purpose of applying the 3-percent limitation, expenses for medicines and drugs are included only to the extent that they exceed 1 percent of adjusted gross income. An exception is presently made to these general rules, however, in the case of medical care expenses incurred by a taxpayer or his spouse if either is 65 or over, or for his dependent mother or father (or mother-in-law or father-in-law) if 65 years of age or more. The expenses for medical care of such persons may be deducted without regard to either the 3-percent or the 1-percent limitations.

Under present law, certain maximum limitations are also imposed with respect to medical expense deductions. With the exception of disabled persons, these maximum limitations do not vary according to age. Generally, the maximum medical expense deduction which may be taken is \$5,000 multiplied by the number of exemptions claimed (other than those for age or blindness), not to exceed \$10,000 in the case of a single taxpayer or \$20,000 in the case of a married couple (or head of household or surviving spouse). In the case of disabled taxpayers and their spouses, however, who have attained the age of 65, the maximum \$10,000 or \$20,000 limitation referred to above is increased to \$20,000 or \$40,000, respectively.

2. GENERAL REASONS FOR PROVISION

The health care provisions of your committee's bill have a relationship to the medical expense deductions allowed under the Internal Revenue Code. The 3-percent limitation in the case of medical care expenses and the 1-percent limitation applied to expenditures for medicines and drugs were waived for persons 65 or over in recognition of the fact that medical expenses generally constituted

a heavy financial burden for older people. The limitations were waived, however, during a period when there was no broad-coverage health insurance plan for older persons. The insurance provisions of your committee's bill are designed to meet these problems. The reasons for the special medical expense provisions in the tax law for the relief of older taxpayers, therefore, no longer appear to exist.

Moreover, restoration of a uniform floor to be applied in the computation of the medical expense deduction will provide an increase in revenue which will help defray to some degree the cost of the general fund of the voluntary insurance provisions in your committee's bill. Only in the case of an older person with sufficient income to be taxable will the benefit of the Federal Government's \$36-per-year contribution towards his voluntary medical insurance coverage be reduced or offset by a lesser deduction for medical care expenses.

Restoration of a uniform medical expense deduction rule also will serve to simplify the tax law. Present law necessitates a careful distinction between the medical care expenses of persons 65 or over and the similar expenses of persons under 65. A complex special form is employed for this purpose. The need for this special form will be eliminated by the establishment of a single uniform rule for those over and under age 65.

The bill also permits, for all persons regardless of age, the deduction of a portion of medical insurance premiums without regard to the 3-percent limitation in recognition of the fact that existing law may have the effect of discouraging the provision of insurance protection against future medical bills. Under present law medical insurance premiums may not be deductible because provision for medical expenses by insurance tends to even out these charges over a period of years and, therefore, makes it more likely that in any specific year the 3-percent limitation will not be exceeded. Medical expenses of those not covered by insurance tend to vary more from year to year and thus in some years are more likely to exceed the 3-percent limitation and be deductible.

3. GENERAL EXPLANATION

Your committee's bill (sec. 106), therefore, amends the Internal Revenue Code (sec. 213) to terminate present special treatment of the medical care expenses of taxpayers who are 65 or over. Thus, the provision of present law limiting medical expense deductions for a taxpayer, his spouse, or his dependents where they are under age 65 to the amount of such expenses in excess of 3 percent of adjusted gross income is extended to all taxpayers, spouses, and dependents regardless of age. This is also true of the provision under present law limiting expenditures for medicines and drugs which are taken into account for purposes of the 3-percent limitation to the amount in excess of 1 percent of adjusted gross income. These limitations, therefore, will, in the future, apply to taxpayers and their spouses who have attained age 65 as well as dependent mothers or fathers of the taxpayer (or of his spouse) who have attained the age of 65.

The bill also removes the distinction in the maximum medical expense deduction allowance between disabled taxpayers over and under age 65. This is accomplished by extending the \$20,000 maximum deduction presently available to single taxpayers and the \$40,000 ceiling

available to married taxpayers filing joint returns to disabled taxpayers under age 65.

The bill further provides that all taxpayers itemizing their deductions, regardless of age, are to be granted a deduction, without regard to the 3-percent floor, for one-half the cost of medical care insurance for the taxpayer, his spouse, and his dependents, but not to exceed \$250. The other half of any premiums paid, plus any excess over the \$250 limit for medical care insurance, will continue to be subject to the 3-percent floor and only when they plus any other allowable medical expenses exceed 3 percent of adjusted gross income will they be deductible. Included in the category of medical insurance premiums which may be deducted (one-half under, and one-half apart from, the 3-percent floor) are those for supplementary health insurance benefits for the aged but not the taxes transferred to the trust fund for hospital insurance benefits for the aged.

The bill also makes certain other amendments to the medical expense deduction provisions of the Internal Revenue Code. The definition of medical care is revised to specifically limit the deductible portion of premiums paid on multipurpose health and accident policies to the actual cost of providing insurance protection against medical care expenses, as defined in the Internal Revenue Code. The cost of insurance allocable to income continuation payments when illness or accident causes absence from work and the cost of insurance which provides indemnity in the case of the loss of a limb, etc., is not to be deductible. This revision becomes particularly important in view of the provision which permits the deduction of one-half of the premiums paid for medical care insurance without regard to the 3-percent limitation.

The bill qualifies as a current medical expense certain premiums paid during the taxable year by a taxpayer under the age of 65 for insurance for the medical care expenses of the taxpayer, his spouse, and his dependents which will be incurred after the taxpayer attains the age of 65. However, these payments, to qualify as a current expense, must be made under a contract which provides for level premium payments over a specified minimum period. This provision, which applies only to insurance for medical care expenses, is designed to remove any impediment which might otherwise exist to the voluntary provision by a person under 65 of medical care protection for his post-65 years. This is not intended, however, to foreclose the allowance of any presently available deduction for other prepayments.

4. EFFECTIVE DATE

These provisions apply to medical care expenses incurred in tax years beginning after December 31, 1966. The provisions will, therefore, not become effective until the health care provisions of the bill have been in operation for 6 months.

5. REVENUE EFFECT

The provision reinstituting the deduction floors is expected to increase revenues by \$170 million but it is expected that the deduction of one-half the cost of medical insurance premiums without regard to the 3-percent limitation will decrease revenues by \$88 million. Overall, it is estimated that the provisions will increase revenues by \$82 million in a full year of operation. This, of course, is much more than offset by health care payments made from the general fund of the Treasury. The distribution of this total by specific provisions and adjusted gross income classes is shown below.

Distribution of tax revenue estimates under revised medical expense deduction

[In millions of dollars]

Adjusted gross income	¹ Application of 3-percent and 1-percent limitations to all taxpayers ²	Increased medical expense deduction ³
0 to \$3,000.....	1	-9
\$3,000 to \$5,000.....	9	-3
\$5,000 to \$10,000.....	20	-31
\$10,000 to \$20,000.....	24	-32
\$20,000 to \$50,000.....	47	-10
\$50,000 and over.....	69	-3
Total.....	170	-88

¹ This additional revenue will be derived from those age 65 and over.

² Assumes a reduction in hospitalization and medical expenses of 50 percent for taxpayers with incomes under \$10,000 and 25 percent for those with incomes over \$10,000.

³ Includes effect of allowing a deduction of 1/2 cost of all medical insurance premiums without regard to the 3-percent limitation and effect of medical expense deductions for premiums paid for voluntary insurance coverage under this bill. This reduction goes to taxpayers of all age groups.

IV. SECTION-BY-SECTION ANALYSIS OF THE BILL

The first section contains the short title of the bill—the “Social Security Amendments of 1965”—and a table of contents. The remainder of the bill is divided into four titles, and titles I and II into several parts, as follows:

- Title I—Health Insurance For the Aged and Medical Assistance
 - Part 1—Health Insurance Benefits for the Aged
 - Part 2—Grants to States for Medical Assistance Programs
- Title II—Other Amendments Relating to Health Care
 - Part 1—Maternal and Child Health and Crippled Children’s Services
 - Part 2—Implementation of Mental Retardation Planning
 - Part 3—Public Assistance Amendments Relating to Health Care
- Title III—Social Security Amendments
- Title IV—Public Assistance Amendments

TITLE I—HEALTH INSURANCE FOR THE AGED AND MEDICAL ASSISTANCE

Section 100 of the bill provides that title I of the bill may be cited as the “Health Insurance for the Aged Act.”

PART 1—HEALTH INSURANCE BENEFITS FOR THE AGED

SECTION 101. ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS

Section 101 of the bill adds at the end of title II of the Social Security Act a new section 226, dealing with entitlement to hospital insurance benefits (i.e., entitlement to have payment of benefits made under part A of the new title XVIII of the Social Security Act (as added by section 102 of the bill)).

Section 226(a) provides that any individual who has attained the age of 65, and who is entitled to monthly old-age and survivors insurance benefits or is a “qualified railroad retirement beneficiary”, is entitled to hospital insurance benefits under part A of the new title XVIII for each month (including, if applicable, any month of retroactive entitlement to monthly OASI benefits as provided in section 202(j)(1) of the Social Security Act and any month of retroactive entitlement to benefits as provided in section 21 of the Railroad Retirement Act of 1937) in which he meets such conditions, beginning with July 1966.

Paragraph (1) of section 226(b) provides that entitlement of an individual to hospital insurance benefits consists of entitlement to have payment made on his behalf for inpatient hospital services,

post-hospital extended care services, post-hospital home health services, and outpatient hospital diagnostic services furnished him in the United States. It also provides that no payment for post-hospital extended care services may be made for services furnished before January 1967 and that payment for post-hospital extended care services or post-hospital home health services may be made only if the discharge from a hospital required to permit payment with respect to such services occurs after June 30, 1966, or on or after the first day of the month in which the individual attains age 65, whichever is later.

Paragraph (2) of section 226(b) provides that an individual entitled under section 226 is entitled to hospital insurance benefits for the month in which he dies.

Section 226(c) provides that the term "qualified railroad retirement beneficiary" means an individual whose name has been certified to the Secretary by the Railroad Retirement Board under section 21 of the Railroad Retirement Act of 1937 (as added by section 105 of the bill), and that an individual will cease to be a qualified railroad retirement beneficiary at the close of the month before the month which is certified by the Board as the month in which he ceased to meet the requirements of such section 21.

Section 226(d) contains a cross-reference to section 103 of the bill which provides entitlement to hospital insurance benefits for certain individuals not eligible for benefits under section 226.

SECTION 102. HOSPITAL INSURANCE BENEFITS AND SUPPLEMENTARY HEALTH INSURANCE BENEFITS

Section 102(a) of the bill amends the Social Security Act by adding after title XVII a new title XVIII providing health insurance for the aged and consisting of part A (hospital insurance for the aged), part B (supplementary health insurance benefits for the aged), and part C (miscellaneous provisions).

TITLE XVIII—HEALTH INSURANCE FOR THE AGED

SECTION 1801. PROHIBITION AGAINST ANY FEDERAL INTERFERENCE

Section 1801 states that nothing in the new title XVIII is to be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine, the manner in which medical services are provided, the personnel policies of providers of health care, or the operation or administration of medical facilities and personnel.

SECTION 1802. FREE CHOICE BY PATIENT GUARANTEED

Section 1802 provides that any individual entitled to benefits under title XVIII may obtain health services from any institution, agency, or person which is qualified to participate under the title and which undertakes to provide the services to him.

SECTION 1803. OPTION TO INDIVIDUALS TO OBTAIN OTHER HEALTH
INSURANCE PROTECTION

Section 1803 provides that nothing in title XVIII is to be construed to preclude any State from providing, or any individual from purchasing or otherwise securing, protection against health costs.

PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED

SECTION 1811. DESCRIPTION OF PROGRAM

Section 1811 describes the insurance program for which entitlement is established under section 226 of the Social Security Act as one which provides basic protection against the costs of hospital and related post-hospital services for individuals age 65 or over who are entitled to retirement benefits under title II of the Social Security Act or under the railroad retirement system.

SECTION 1812. SCOPE OF BENEFITS

Section 1812(a) provides that the benefits provided to an individual under part A of the new title XVIII consist of entitlement to have payment made on his behalf for:

- (1) inpatient hospital services (including such services in a tuberculosis hospital) for up to 60 days during any spell of illness;
- (2) post-hospital extended care services for up to 20 days (or up to 100 days in the circumstances described in section 1812(c)) during any spell of illness;
- (3) post-hospital home health services for up to 100 visits (during the one-year period described in section 1861(n)) after the beginning of one spell of illness and before the beginning of the next; and
- (4) outpatient hospital diagnostic services.

Section 1812(b) provides that (subject to section 1812 (c) and (d), discussed below) payment may not be made for inpatient hospital services furnished to an individual in any spell of illness after such services have been furnished to him for 60 days during the spell or for post-hospital extended care services in any spell of illness after such care has been furnished to him for 20 days during the spell.

Section 1812(c) provides that, at the individual's option, the number of days for which payment for post-hospital extended care services may be made can be increased beyond 20 (but by no more than 80 days, for a maximum of 100) by twice the number by which the days for which the individual has already been furnished inpatient hospital service in the same spell of illness are less than 60. The number of days of inpatient hospital care for which payments could be made during the same spell of illness would be reduced by one day for each full two days of extended care above 20 for which payment is made (and by an additional day if the number of days of extended care is an odd number). The individual may conserve his inpatient hospital coverage by terminating the application of section 1812(c) at any time.

To illustrate the effect of section 1812(c), if an individual transferred to an extended care facility after a 10-day hospital stay and needed 63 days of extended care facility services, payment would be made

for the entire stay in the facility, including the 43 days beyond the initial 20, unless he elects to have payment cut off for some or all of the 43 days. If payment is made for the entire period of extended care he would, after discharge from the facility, remain eligible for 28 additional days of hospital care if he should need to be hospitalized again during the same spell of illness. That is, of the 60 days of hospital benefits, he would have received 10 days of benefits in the hospital, and he would have exchanged 22 days of hospital benefits for the 43 additional days of extended care benefits, leaving him with a balance of 28 days of hospital care. However, if the individual had requested that his days in the extended care facility beyond 20 not be paid for, he would have retained a balance of 50 days of hospital care.

Section 1812(d) provides that if an individual is an inpatient of a tuberculosis hospital on the first day of the first month for which he is entitled to benefits under part A, the days on which he was an inpatient of such a hospital in the 60-day period immediately before such first day will be included in determining the 60-day limit on inpatient hospital services insofar as it applies to him.

Section 1812(e) provides that payment may be made under part A for post-hospital home health services furnished an individual only during the one-year period described in section 1861(n) following his most recent hospital discharge which meets the requirements of such section. Only the first 100 visits in the one-year period can be paid for. The number of visits to be charged in connection with the provision of covered home health items or services for this purpose is to be determined in accordance with regulations.

Section 1812(f) provides that inpatient hospital services, post-hospital extended care services, and post-hospital home health services will be taken into account for purposes of the limits on duration of coverage prescribed in the preceding subsections of section 1812 only if payment under part A is made or would be made with respect to such services if they had been furnished within such limits and if the request and certification requirements described in section 1814(a) had been met for such services.

Section 1812(g) contains a cross reference to the definitions of the terms used in part A which are found in section 1861.

SECTION 1813. DEDUCTIBLES

Paragraph (1) section 1813(a) provides that payment for inpatient hospital services furnished during any spell of illness will be reduced by the inpatient hospital deductible (the amount of which is determined under section 1813(b)). However, charges for a diagnostic study, up to the amount of the deductible which applies to a diagnostic study (described in paragraph (2)), by the same hospital during the 20-day period before the individual is admitted as an inpatient to the hospital, would be applied toward the inpatient hospital deductible.

To illustrate: An individual obtains diagnostic laboratory services in a hospital outpatient department on August 1, 1966, and is charged \$15 for these services. On August 15 he is admitted as an inpatient to the same hospital in which he received the diagnostic services. He is permitted to apply his payment for the diagnostic services toward the inpatient hospital deductible (\$40 in 1966); thus he would have to pay an inpatient hospital deductible of \$25.

Paragraph (2) of section 1813(a) provides for a deductible with respect to outpatient hospital diagnostic services (furnished during a diagnostic study) equal to one-half the amount of the inpatient hospital deductible. A "diagnostic study" is defined as outpatient hospital diagnostic services provided by (or under arrangements made by) the same hospital during the 20-day period beginning on the first day (once he is entitled to benefits under section 226) on which outpatient hospital diagnostic services are furnished to him.

Paragraph (3) of section 1813(a) provides that payment cannot be made to any provider of services under part A for the cost of the first 3 pints of whole blood furnished to an individual during a spell of illness.

Paragraph (1) of section 1813(b) provides that the inpatient hospital deductible is \$40 for any spell of illness (and is therefore \$20 for any diagnostic study) beginning before 1969.

Paragraph (2) of section 1813(b) provides that the Secretary shall, between July 1 and October 1 of 1968, and of each year thereafter, determine and promulgate the inpatient hospital deductible which is to be applicable in the case of any spell of illness or diagnostic study beginning during the succeeding calendar year. The inpatient hospital deductible will be equal to \$40 multiplied by the ratio of (A) the current average per diem rate for inpatient hospital services for the preceding calendar year, to (B) the current average per diem rate for 1966. Any amount determined by the multiplication under this paragraph which is not a multiple of \$5 will be rounded to the nearest multiple of \$5 (or, if it is midway between two multiples of \$5, to the next higher multiple of \$5).

If, for example, the cost experience reviewed for purposes of the promulgation to be made in 1970 shows that the average per diem rate for inpatient hospital services during 1969 was \$45.55 as compared to \$39.80 in 1966, the amount of the deductible applicable in 1971

would be \$45 (\$40 multiplied by $\frac{45.55}{39.80}$ and then rounded to the nearest multiple of \$5).

The current average per diem rate for any year will be determined by the Secretary on the basis of the best information available to him as to the amounts paid under part A for inpatient hospital services plus the amounts which would have been paid but for the inpatient hospital deductible required under section 1813(a)(1).

SECTION 1814. CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

Requirement of requests and certifications

Section 1814(a) provides that, except in the case of emergency hospital services (described in section 1814(d)), payment for covered services may be made only to providers of services which have an agreement with the Secretary entered into in accordance with section 1866 and only if the requirements of section 1814(a) with respect to requests and certifications are satisfied.

Paragraph (1) of section 1814(a) requires that a written request (signed by the individual who receives the services or by another

person when it is impracticable for him to do so) be filed for such payment under regulations to be issued by the Secretary.

Paragraph (2) of section 1814(a) requires that a physician certify (and recertify, in such cases and as often and with such supporting material as may be provided in regulations, but in any event before the 21st day in the case of inpatient hospital services received during a continuous period) that—

(A) in the case of inpatient hospital services (other than inpatient tuberculosis hospital services), the services were required to be given on an inpatient basis for medical treatment, or inpatient diagnostic study was medically required;

(B) in the case of inpatient tuberculosis hospital services, the services were required to be given on an inpatient basis by or under the supervision of a physician for the treatment of tuberculosis, and the treatment can be reasonably expected to improve the condition or render it noncommunicable;

(C) in the case of post-hospital extended care services, the services were required to be given on an inpatient basis because the individual needed skilled nursing care on a continuing basis for a condition for which he was hospitalized prior to transfer to the extended care facility, or which arose while receiving such care for such a condition;

(D) in the case of post-hospital home health services, the services were required because the individual was confined to his home (except when receiving services referred to in section 1861(m)(7)) and needed intermittent skilled nursing care, or physical or speech therapy, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would qualify as inpatient services if the institution met certain specified requirements) or post-hospital extended care services, and the services were furnished while the individual was under the care of a physician and under a plan established and reviewed periodically by a physician; or

(E) in the case of outpatient hospital diagnostic services, the services were required for diagnostic study.

Under the last sentence of section 1814(a), to the extent provided by regulations, the certification and recertification requirements of paragraph (2) would be deemed satisfied where a physician makes the certification or recertification at a date later than the day it was required under paragraph (2), if it is accompanied by such medical or other evidence as may be required by regulations.

Paragraph (3) of section 1814(a) provides that, in the case of inpatient tuberculosis hospital services, payment may be made only if the services are those which the records of the hospital indicate were furnished during periods when the individual was receiving treatment which could reasonably be expected to improve his condition or render it noncommunicable.

Paragraph (4) of section 1814(a) provides that payment may not be made for inpatient hospital services furnished an individual after the 20th day of a continuous stay or for post-hospital extended care services furnished continuously after a period of time prescribed in regulations if the Secretary, before such individual's admission to the hospital or extended care facility, has rendered an adverse decision under section 1866(d) after a finding that the hospital or extended

care facility is not making the necessary utilization reviews of long-stay cases.

Paragraph (5) of section 1814(a) provides that payment may not be made for inpatient hospital services or post-hospital extended care services furnished an individual during a continuous period after a finding (as described in section 1861(k)(4)) by the physician members of the appropriate utilization review committee that further inpatient hospital services or post-hospital extended care services are medically unnecessary. If such a finding has been made, payment may be made for services furnished through the 3rd day after the day the notice of such finding is received by the hospital or extended care facility.

Reasonable cost of services

Section 1814(b) provides that the amount to be paid any provider for services under part A is the reasonable cost of such services (subject to the deductibles under sec. 1813), as determined under section 1861(v) (discussed below).

No payments to Federal providers of services

Section 1814(c) provides that no payment is to be made to a Federal provider of services, except for emergency services, unless the Secretary determines that the provider is furnishing services to the public generally as a community institution or agency. Payment may not be made to any provider for any item or service which it is required to render at public expense under a law of or contract with the United States.

Payments for emergency hospital services

Section 1814(d) provides that payment may be made for emergency hospital services, in the absence of an agreement of the kind otherwise required between the Secretary and the hospital, to the extent that the Secretary would be required to make payment if the hospital had such an agreement in effect and otherwise meets the conditions of payment. (See section 1861(e) for the definition of a hospital eligible under this provision.) The hospital would have to agree, as a condition of payment under this provision, not to charge the patient for the emergency services.

Payment for inpatient hospital services prior to notification of non-eligibility

Section 1814(e) provides that if a hospital has acted reasonably and in good faith in assuming that an individual was entitled to have payment made for inpatient hospital services under part A, the hospital can receive payment for such services furnished to the individual, even though he is not entitled to have such payment made, prior to notification from the Secretary that the individual is not so entitled. However, this provision would apply only if such payment is precluded solely because the individual has used up his 60 days of entitlement to inpatient hospital services in the spell of illness; and no payment may be made unless the hospital refunds any payment already obtained from the individual or on his behalf with respect to the services involved. In any event, payment may not be made under this provision for services furnished an individual after the 6th elapsed day after the day of his admission to the hospital (not counting

Saturday, Sunday, or a legal holiday as an elapsed day). Payment to the hospital under section 1814(e) would constitute an overpayment to the individual (and could be recovered) under section 1870.

SECTION 1815. PAYMENT TO PROVIDERS OF SERVICES

Section 1815 provides that the Secretary will determine the amounts to be paid to providers of services under part A (such amounts to be paid not less often than monthly) from the Federal Hospital Insurance Trust Fund. The provider must furnish such information as the Secretary may request in order to determine the amounts to be paid to the provider.

SECTION 1816. USE OF PUBLIC AGENCIES OR PRIVATE ORGANIZATIONS TO FACILITATE PAYMENT TO PROVIDERS OF SERVICES

Section 1816(a) provides that if any group or association of providers of services wishes to have payments under part A made through a national, State, or other public or private agency or organization and nominates an agency or organization for this purpose, the Secretary may enter into an agreement with the agency or organization providing for the determination (subject to such review by the Secretary as may be provided for in the agreement) of the amounts to be paid under part A to such providers, and for the payment to such providers of the amounts so determined. The agreement could also include provision for the agency or organization to do all or any part of the following: (1) provide consultative services to institutions or agencies to enable them to establish and maintain fiscal records and otherwise to qualify as participants in the program; and (2) serve as a center for communications between the providers covered under the agreement and the Secretary, make such audits of the records of such providers as may be necessary to assure proper payment, and perform such other functions as are necessary to carry out section 6181(a).

Section 1816(b) provides that the Secretary is not to enter into an agreement with an agency or organization under section 1816(a) unless he finds that (1) to do so is consistent with effective and efficient administration, (2) the agency or organization is willing and able to assist the providers in the application of safeguards against unnecessary utilization of services (and the agreement provides for such assistance), and (3) the agency or organization agrees to furnish to the Secretary such information acquired by it in carrying out its agreement as the Secretary may find necessary to perform his functions under part A.

Section 1816(c) provides that an agreement with an agency or organization under section 1816(a) may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the agency or organization for making payments to providers of services. Such an agreement will also provide for payment to the agency or organization of the necessary and proper costs of carrying out its functions performed or to be performed under the terms of the agreement.

Section 1816(d) provides that if the nomination of an agency or organization is made by a group or association of providers of services, it will not be binding on members of such group or association which

notify the Secretary of their election to that effect. Any provider may, upon notice, withdraw its nomination to receive payments through such agency or organization. Any provider which has withdrawn its nomination (and any provider which has not made a nomination) may elect to receive payments either directly from the Secretary or from any agency or organization which has entered into an agreement with the Secretary under section 1816(a) if the Secretary and such agency or organization agree to it.

Section 1816(e) provides that an agreement with the Secretary under section 1816(a) may be terminated by the agency or organization at such time and upon such notice as may be provided in regulations. An agreement may also be terminated by the Secretary at such time and upon such notice as may be provided in regulations, but only if he finds (after reasonable notice and opportunity for hearing) that the agency or organization has failed substantially to carry out the agreement or that the continuation of the agreement is disadvantageous or is inconsistent with the efficient administration of part A.

Section 1816(f) provides that an agreement with any agency or organization under section 1816(a) may require any of its officers or employees who are participating in carrying out the agreement to give surety bond to the United States in such amount as the Secretary may deem appropriate.

Paragraph (1) of section 1816(g) provides that no individual designated pursuant to such an agreement as a certifying officer will, in the absence of gross negligence or intent to defraud the United States, be liable for any payments incorrectly certified by him.

Paragraph (2) of section 1816(g) provides a similar immunity for disbursing officers who make an incorrect payment based upon a voucher signed by a certifying officer designated as provided in paragraph (1).

SECTION 1817. FEDERAL HOSPITAL INSURANCE TRUST FUND

Section 1817(a) creates the Federal Hospital Insurance Trust Fund, which will consist of amounts deposited in or appropriated to it as provided in part A. For the fiscal year ending June 30, 1966, and for each fiscal year thereafter, there are appropriated to the Trust Fund amounts equal to (1) the taxes imposed by sections 3101(b) and 3111(b) of the Internal Revenue Code of 1954 on wages reported to the Secretary of the Treasury after December 31, 1965, and (2) the taxes imposed by section 1401(b) of the Internal Revenue Code of 1954 on self-employment income reported to the Secretary of the Treasury on tax returns. These wages and self-employment income are to be certified by the Secretary of Health, Education, and Welfare on the basis of records established and maintained by him in accordance with such reports and returns. The amounts to be appropriated, which will be determined by the Secretary of the Treasury on the basis of estimates of the taxes, are to be transferred from time to time from the general fund of the Treasury to the Trust Fund, with adjustments being made for prior estimates which were greater or lesser than the taxes.

Section 1817(b) creates the Board of Trustees of the Trust Fund, to be composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health, Education, and Welfare. The Board of

Trustees will meet at least once each calendar year. The Secretary of the Treasury will be the Managing Trustee of the Board of Trustees, and the Commissioner of Social Security will serve as the Secretary of the Board. The Board of Trustees will (1) hold the Trust Fund; (2) report to the Congress by March 1 of each year on the operation and status of the Trust Fund for the preceding fiscal year and on its expected operation and status for the current fiscal year and the next 2 fiscal years; (3) report immediately to the Congress whenever the Board believes that the amount of the Trust Fund is unduly small; and (4) review the general policies followed in managing the Trust Fund and recommend changes in those policies, including necessary changes in the provisions of the law which govern the way in which the Trust Fund is to be managed. The report on the status and operation of the Trust Fund is to include a statement of the assets of and disbursements from the Fund during the preceding year, an estimate of income and disbursements for the current fiscal year and each of the next 2 fiscal years, and a statement of the actuarial status of the Trust Fund, and is to be printed as a House document of the session of the Congress to which the report is made.

Section 1817(c) provides that it is the duty of the Managing Trustee to invest the portion of the Trust Fund which, in his judgment, is not required to meet current withdrawals. These investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. They may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price. The Second Liberty Bond Act is extended to authorize the issuance at par, for purchase by the Trust Fund, of public-debt obligations having maturities fixed with due regard for the needs of the Trust Fund and bearing interest at a rate equal to the average market yield on all marketable interest-bearing obligations of the United States which are a part of the public debt at the end of the calendar month preceding the date of issue and which are not due or callable until after 4 years from such month. If the average market yield is not a multiple of one-eighth of one percent, the rate of interest will be the multiple of one-eighth of one percent nearest the market yield. Other interest-bearing obligations of the United States or obligations guaranteed by the United States may be purchased by the Managing Trustee only when he determines it is in the public interest.

Section 1817(d) provides that any obligations acquired by the Trust Fund may be sold by the Managing Trustee at the market price, except public-debt obligations issued exclusively to the Trust Fund, which may be redeemed at par plus accrued interest.

Section 1817(e) provides that the interest on and proceeds from the sale of any obligations held in the Trust Fund will be credited to and form a part of the Fund.

Paragraph (1) of section 1817(f) directs the Managing Trustee to pay from time to time from the Trust Fund into the Treasury the amount estimated by him as taxes imposed under section 3101(b) of the Internal Revenue Code of 1954 which are subject to refund under section 6413(c) of the Code with respect to wages paid after December 31, 1965. Such taxes are to be determined on the basis of the records of wages established and maintained by the Secretary of Health,

Education, and Welfare in accordance with the wages reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Code, and the Secretary will furnish the Managing Trustee such information as may be required for this purpose. The payments are to be covered into the Treasury as repayments to the account for refunding internal revenue collections.

Paragraph (2) of section 1817(f) provides that repayments under paragraph (1) will not be available for expenditures but will be carried to the surplus fund of the Treasury.

Section 1817(g) provides for the transfer at least once each fiscal year to the Trust Fund, from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, of amounts equal to the amounts certified by the Secretary as overpayments under section 1870(b). It also provides for the transfer at least once each fiscal year to the Trust Fund from the Railroad Retirement Account of amounts equal to the amounts certified by the Secretary as overpayments to the Railroad Retirement Board under section 1870(b). These amounts represent the overpayments which are to be collected by reducing the cash monthly benefits payable to (or on the wage record of) the individual involved under title II of the Social Security Act or under the Railroad Retirement Act of 1937.

Section 1817(h) provides that the Managing Trustee will also pay from time to time from the Trust Fund such amounts as the Secretary of Health, Education, and Welfare certifies are necessary to pay the benefits provided by part A and the administrative expenses in accordance with section 201(g)(1) of the Act.

PART B—SUPPLEMENTARY HEALTH INSURANCE BENEFITS FOR THE AGED

SECTION 1831. ESTABLISHMENT OF SUPPLEMENTARY HEALTH INSURANCE PROGRAM FOR THE AGED

Section 1831 establishes a voluntary health insurance program for individuals aged 65 or over to be financed from premium payments by enrollees together with contributions from funds appropriated by the Federal Government.

SECTION 1832. SCOPE OF BENEFITS

Section 1832(a) provides that the benefits made available to an individual under the insurance program established by part B consist of—

(1) entitlement to have payment made to him or on his behalf for physicians' services, and for medical and other health services not furnished by (or under arrangements with) a provider of services (such as a hospital or home health agency); and

(2) entitlement to have payment made on his behalf for (A) inpatient psychiatric hospital services for up to 60 days during a spell of illness; (B) home health services for up to 100 visits during a calendar year (without regard to whether or not the individual has been in a hospital); and (C) medical and other health services furnished by a provider of services (or by others under arrangements with them).

Section 1832(b) contains a cross reference to the definitions of "spell of illness", "medical and other health services", and other terms used in part B which are found in section 1861.

SECTION 1833. PAYMENT OF BENEFITS

Section 1833(a) provides that payment will be made from the Federal Supplementary Health Insurance Benefits Trust Fund, in the case of each individual covered under the insurance program established by part B who incurs expenses for services, for 80 percent of the reasonable charges for physicians' services and for medical and other health services described in 1832(a)(1), and for 80 percent of the reasonable cost (as determined under section 1861(v)) of inpatient psychiatric hospital services, home health services, and medical and other health services described in section 1832(a)(2).

Section 1833(b) provides that, before any payment is made by the program for covered expenses incurred by an individual during any calendar year, the individual must meet a deductible of \$50. However, the deductible for any year will be reduced by the amount of any expenses which the individual incurred in the last 3 months of the preceding calendar year and which were applied toward the \$50 deductible in such preceding year.

Section 1833(c) provides that (notwithstanding any other provision of part B) expenses incurred in any calendar year for the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital at the time will be considered as incurred expenses for purposes of section 1833(a) and (b) only to the extent of \$312.50 or 62½ percent of the expenses, whichever is smaller. When the 80-percent coinsurance under section 1833(a) is applied to these limits, the actual dollar amount which can be paid under part B for such outpatient psychiatric expenses is \$250 or 50 percent of the charges, whichever is less (subject to the deductible under section 1833(b) unless other expenses have been used to satisfy it).

Section 1833(d) provides that expenses for whole blood furnished during a spell of illness to an individual in a hospital will be considered as incurred expenses for purposes of section 1833(a) and (b) only if he has already received 3 pints of whole blood during the same spell.

Section 1833(e) provides that payment may not be made under part B for services furnished an individual if such individual is entitled (or would be entitled except that the expenses involved were used in satisfying a deductible) to have payment made for those services under part A.

Section 1833(f) provides that no payment will be made under part B unless the information necessary to determine the amounts due has been furnished.

SECTION 1834. DURATION OF SERVICES

Paragraph (1) of section 1834(a) provides that payment may not be made under part B for inpatient psychiatric hospital services furnished an individual after such services have been furnished to him for 60 days during a spell of illness, and no payment may be made after these services have been furnished to him for a total of 180 days during his lifetime.

Paragraph (2) of section 1834(a) provides that if an individual is an inpatient of a psychiatric hospital on the first day on which he is entitled to benefits under part B (which could be as early as July 1, 1966), the days on which he was an inpatient of such a hospital in the 60-day period immediately before such first day are to be included in determining the 60-day limit under paragraph (1) but not in determining the 180-day limit under such paragraph. For example, if an individual became covered under part B on July 1, 1966, and had been in a psychiatric hospital since June 1, 1966, he would be covered for only his first 30 days as an inpatient of a psychiatric hospital in his spell of illness beginning July 1. However, the 30 days in June would not be counted toward his lifetime maximum of 180 days.

Section 1834(b) provides that payment may not be made under part B for home health services furnished an individual during any calendar year after such services have been furnished to him for 100 visits during the year. The charging of visits in connection with the provision of covered home health items and services for this purpose is to be determined in accordance with regulations.

Section 1834(c) provides that inpatient psychiatric hospital services and home health services will be taken into account for purposes of the limits on duration of coverage prescribed in section 1834 (a)(1) and (b) only if payment under part B is made or would be made if the services had been furnished within such limits and the request and certification requirements described in section 1835(a) had been met for such services.

SECTION 1835. PROCEDURE FOR PAYMENT OF CLAIMS OF PROVIDERS OF SERVICES

Section 1835(a) provides that payment for the services described in section 1832(a)(2) (inpatient psychiatric hospital services, home health services, and medical and other health services) may be made only to providers of services which have an agreement with the Secretary under section 1866 and only if the requirements of section 1835(a) with respect to requests and certifications are satisfied.

Paragraph (1) of section 1835(a) requires that a written request (signed by the individual who received the services or by another person when it is impracticable for him to do so) be filed for such payment under regulations issued by the Secretary.

Paragraph (2) of section 1835(a) requires that a physician certify (and recertify, in such cases and as often and with such supporting material as may be provided in regulations, but in any event before the 21st day in the case of inpatient psychiatric hospital services received during a continuous period) that—

(A) in the case of inpatient psychiatric hospital services, the services were required to be given on an inpatient basis for psychiatric treatment by or under the supervision of a physician and such treatment could reasonably be expected to improve the condition, or inpatient diagnostic study was medically required;

(B) in the case of home health services, the services were required because the individual was confined to his home (except when receiving services referred to in sec. 1861(m)(7)) and needed intermittent skilled nursing care, or physical or speech therapy, and the services were furnished while the individual is

or was under the care of a physician and under a plan established and reviewed periodically by a physician; or

(C) in the case of medical and other health services, the services were medically required.

Under the last sentence of section 1835(a), to the extent provided by regulations, the certification and recertification requirements of paragraph (2) will be deemed satisfied where a physician makes the certification or recertification at a date later than the day it was required under paragraph (2), if it is accompanied by such medical or other evidence as may be required by regulations.

Paragraph (3) of section 1835(a) provides that, in the case of inpatient psychiatric hospital services, payment may be made only if the services are those which the records of the hospital indicate were furnished during periods when the individual was receiving intensive treatment services, services necessary for a diagnostic study, or equivalent services.

Paragraph (4) of section 1835(a) provides that payment may not be made for inpatient psychiatric hospital services furnished an individual after the 20th day of a continuous stay if the Secretary, before such individual's admission to the hospital, has rendered an adverse decision under section 1866(d) after finding that the hospital is not making utilization reviews of long-stay cases.

Paragraph (5) of section 1835(a) provides that payment may not be made for inpatient psychiatric hospital services furnished an individual during a continuous period after a finding (as described in section 1861(k)(4)) by the physician members of the appropriate utilization review committee that further inpatient psychiatric hospital services are medically unnecessary. If such a finding has been made, payment may be made for services furnished through the 3d day after the day the notice of such finding is received by the hospital.

Section 1835(b) provides that no payment is to be made under part B to a Federal provider of services unless the Secretary determines that the provider is furnishing services to the public generally as a community institution or agency (St. Elizabeths Hospital in Washington, D.C., for example). Payment may not be made to any provider for any item or service which it is required to render at public expense under a law of or contract with the United States.

Section 1835(c) provides that if a psychiatric hospital has acted reasonably and in good faith in assuming that an individual was entitled to benefits under part B, the hospital can receive payment for inpatient hospital services furnished to the individual, even though he is not entitled to have such payment made, prior to notification from the Secretary that the individual is not so entitled. However, this provision would apply only if such payment is precluded solely because the individual has used up his 60 days of entitlement in the spell of illness; and no payment may be made unless the hospital refunds any payment already received from the individual or on his behalf with respect to the services involved. In any event, payment may not be made under this provision for services furnished an individual after the 6th elapsed day after the day of his admission to the hospital (not counting Saturday, Sunday, or a legal holiday as an elapsed day). Payment to the hospital under section 1835(c) would constitute an overpayment to the individual (and could be recovered) under section 1870.

SECTION 1836. ELIGIBLE INDIVIDUALS

Section 1836 provides that every individual who has attained the age of 65 and is a resident of the United States, and is either a citizen or an alien lawfully admitted for permanent residence, is eligible to enroll in the insurance program established by part B. (However, sec. 104(b)(2) of the bill provides that a person convicted of certain offenses related to the national security may not enroll under pt. B.)

SECTION 1837. ENROLLMENT PERIODS

Section 1837(a) provides that an individual may enroll in the insurance program established by part B only in such manner and form as may be prescribed in regulations, and only during an enrollment period described in section 1837.

Paragraph (1) of section 1837(b) provides that no individual may enroll for the first time under part B more than 3 years after the close of the first enrollment period during which he could have enrolled.

Paragraph (2) of section 1837(b) provides that an individual whose enrollment under part B has terminated may not enroll for a second time unless he does so in a general enrollment period (as provided in section 1837(e)) which begins within 3 years after the effective date of such termination. No individual may enroll under part B more than twice.

Section 1837(c) provides that the initial general enrollment period is to begin on the first day of the second month which begins after the date of enactment of the bill and is to end on March 31, 1966. This initial general enrollment period is open to individuals who meet the eligibility requirements of section 1836 before January 1, 1966.

Section 1837(d) provides that the initial enrollment period for an individual who first meets the eligibility requirements of section 1836 on or after January 1, 1966, is to begin on the first day of the third month before the month in which he first meets the eligibility requirements and is to end 7 months later. For example, if a resident citizen becomes 65 in April 1967, his enrollment period begins with January 1, 1967, and ends with July 31, 1967.

Section 1837(e) provides that there is to be a general enrollment period from October 1 to December 31 of each odd-numbered year beginning with 1967.

SECTION 1838. COVERAGE PERIOD

Section 1838(a) provides that an individual's coverage period (the period during which he is entitled to benefits under the insurance program established by part B and the period for which premiums are due) will begin on July 1, 1966, or on the first day of the third month following the month in which he enrolls in his initial enrollment period pursuant to section 1837(d), or on the July 1 following the month in which he enrolls in a general enrollment period pursuant to section 1837(e), whichever is the latest.

Section 1838(b) provides that an individual's coverage period will continue until his enrollment has been terminated (1) by the filing of notice, during a general enrollment period, that he no longer wishes to participate in the program, or (2) for nonpayment of premiums. The termination of a coverage period by the filing of such a notice will take

effect at the close of December 31 of the year in which the notice is filed; a termination for nonpayment of premiums will take effect on a date determined under regulations, which may provide a grace period of up to 90 days during which overdue premiums may be paid and the coverage period continued.

Section 1838(c) provides that payment may be made under part B only for expenses incurred by an individual during his coverage period.

SECTION 1839. AMOUNTS OF PREMIUMS

Section 1839(a) provides that the monthly premium for each individual enrolled under part B for each month before 1968 is to be \$3.

Paragraph (1) of section 1839(b) provides that for each month after 1967 the amount of the monthly premium of each individual enrolled under part B will be determined under paragraph (2).

Paragraph (2) of section 1839(b) provides that the Secretary, between July 1 and October 1 of 1967 and of each odd-numbered year thereafter, will determine and promulgate the dollar amount which is to be applicable for premiums for months occurring in the 2 succeeding calendar years. Such dollar amount will be the amount the Secretary estimates to be necessary so that the aggregate premiums for such 2 succeeding calendar years will equal one-half of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Health Insurance Benefits Trust Fund for the 2 succeeding years. In estimating aggregate benefits payable for any period, the Secretary will include an appropriate amount for a contingency margin.

Section 1839(c) provides that in the case of an individual whose coverage period begins pursuant to an enrollment after his initial enrollment period (as determined by sec. 1837 (c) or (d)), the monthly premium determined under section 1839(b) will be increased by 10 percent of the monthly premium so determined for each full 12 months in which he could have been but was not enrolled. For these purposes there will be taken into account (1) the months which elapsed between the close of his initial enrollment period and the close of the enrollment period in which he enrolled, plus (in the case of an individual who enrolls for a second time) (2) the months which elapsed between the date of the termination of his first coverage period and the close of the enrollment period in which he enrolled for the second time.

Section 1839(d) provides that if any monthly premium determined under the preceding provisions of section 1839 is not a multiple of 10 cents, it is to be rounded to the nearest multiple of 10 cents.

SECTION 1840. PAYMENT OF PREMIUMS

Paragraph (1) of section 1840(a) provides that the monthly premium of an individual who is entitled to monthly social security benefits under section 202 is to be collected (except as provided in subsec. (d)) by deducting the premium from the amount of such benefits. The deductions called for under this paragraph will be made in accordance with regulations of the Secretary.

Paragraph (2) of section 1840(a) provides that the Secretary of the Treasury is to transfer periodically from the Federal Old-Age and Survivors Insurance Trust Fund, and from the Federal Disability

Insurance Trust Fund (for example, for premiums deducted in the case of a woman aged 65 or over entitled to benefits as the wife of a disability beneficiary under age 65), to the Federal Supplementary Health Insurance Benefits Trust Fund, the total amount deducted under paragraph (1). Such transfers are to be made on the basis of certifications by the Secretary of Health, Education, and Welfare and will be adjusted to the extent that prior transfers were too great or too small.

Paragraph (1) of section 1840(b) provides that the monthly premium of an individual who is entitled to receive an annuity or pension for a month under the Railroad Retirement Act of 1937 is to be collected (except as provided in subsec. (d)) by deducting the premium from such annuity or pension. The deductions called for under this paragraph will be made in accordance with regulations of the Secretary (prescribed after consultation with the Railroad Retirement Board).

Paragraph (2) of section 1840(b) provides that the Secretary of the Treasury is to transfer periodically from the Railroad Retirement Account to the Federal Supplementary Health Insurance Benefits Trust Fund the total amount deducted under paragraph (1). Such transfers are to be made on the basis of certifications by the Railroad Retirement Board and will be adjusted to the extent that prior transfers were too great or too small.

Section 1840(c) provides that if an individual is entitled both to monthly social security benefits under section 202 and to an annuity or pension under the Railroad Retirement Act of 1937 at the time he enrolls under part B, or if he becomes simultaneously entitled both to such benefits and such annuity or pension after he enrolls, section 1840(a) will apply (i.e., the deduction for premiums will be made from his social security benefits); except that in the latter case, if the first month for which he was entitled to social security benefits was later than the first month for which he was entitled to a railroad retirement annuity or pension, then section 1840(b) will apply (i.e., the deduction for premiums will continue to be made from such annuity or pension).

Section 1840(d) provides that if an individual estimates that the amount which will be available for deduction under section 1840 (a) or (b) for any premium payment period will be less than the amount of the monthly premiums during that period, so that his premiums could not be deducted from his benefits on a month-to-month basis, he may (under regulations) pay to the Secretary such portion of the monthly premiums for such period as he desires. For example, if an individual has earnings such that under the retirement test no cash social security benefits are payable to him during a year, he can pay his premiums over the course of the year (in accordance with regulations) rather than having them collected from future benefits.

Section 1840(e) provides that for an individual who participates in the insurance program established by part B but to whom neither section 1840(a) nor 1840(b) applies (i.e., who is neither a social security nor a railroad retirement beneficiary), the premiums are to be paid to the Secretary at such times and in such manner as may be prescribed by regulations.

Section 1840(f) provides that amounts paid to the Secretary under section 1840 (d) or (e) are to be deposited in the Treasury to the credit of the Federal Supplementary Health Insurance Benefits Trust Fund.

Section 1840(g) provides that the premiums for an individual enrolled under part B will be payable for the period commencing with the first month of his coverage period and ending with the month in which he dies or, if earlier, in which his coverage period ends.

SECTION 1841. FEDERAL SUPPLEMENTARY HEALTH INSURANCE BENEFITS
TRUST FUND

Section 1841(a) creates the Federal Supplementary Health Insurance Benefits Trust Fund, which will consist of amounts deposited in or appropriated to it as provided in part B.

Section 1841(b) creates the Board of Trustees of the Trust Fund, which is to meet at least once each calendar year and will be composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health, Education, and Welfare. The Secretary of the Treasury will be the Managing Trustee of the Board of Trustees, and the Commissioner of Social Security will serve as the Secretary of the Board. The Board of Trustees will (1) hold the Trust Fund; (2) report to the Congress by March 1 of each year on the operation and status of the Trust Fund for the preceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years; (3) report immediately to the Congress whenever the Board believes that the amount of the Trust Fund is unduly small; and (4) review the general policies followed in managing the Trust Fund and recommend changes therein, including necessary changes in the provisions of the law which govern the way in which the Trust Fund is to be managed. The report on the status and operation of the Trust Fund is to include a statement of the assets of and disbursements from the Fund during the preceding year, an estimate of income and disbursements during the current fiscal year and each of the next 2 fiscal years, and a statement of the actuarial status of the Trust Fund, and is to be printed as a House document of the session of the Congress to which the report is made.

Section 1841(c) provides that it is the duty of the Managing Trustee to invest the portion of the Trust Fund which, in his judgment, is not required to meet current withdrawals. These investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. They may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price. The Second Liberty Bond Act is extended to authorize the issuance at par, for purchase by the Trust Fund, of public-debt obligations having maturities fixed with due regard for the needs of the Trust Fund and bearing interest at a rate equal to the average market yield on all marketable interest-bearing obligations of the United States which are a part of the public debt at the end of the calendar month preceding the date of issue and which are not due or callable until after 4 years from such month. If the average market yield is not a multiple of one-eighth of 1 percent, the rate of interest will be the multiple of one-eighth of 1 percent nearest the market yield. Other interest-bearing obligations of the United States or obligations guaranteed by the United States may be purchased by the Managing Trustee only when he determines it is in the public interest.

Section 1841(d) provides that any obligations acquired by the Trust Fund may be sold by the Managing Trustee at the market price, except public-debt obligations issued exclusively to the Trust Fund, which may be redeemed at par plus accrued interest.

Section 1841(e) provides that the interest on and proceeds from the sale of any obligations held in the Trust Fund will be credited to and form a part of the Fund.

Section 1841(f) provides for the transfer at least once each fiscal year to the Trust Fund, from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, of amounts equal to the amounts certified by the Secretary of Health, Education, and Welfare as overpayments under section 1870(b). It also provides for the transfer at least once each fiscal year to the Trust Fund from the Railroad Retirement Account of amounts equal to the amounts certified by the Secretary as overpayments to the Railroad Retirement Board under section 1870(b). These amounts represent the overpayments which are to be collected by reducing the cash monthly benefits payable to (or on the wage record of) the individual involved under title II of the Social Security Act or under the Railroad Retirement Act of 1937.

Section 1841(g) provides that the Managing Trustee will also pay from time to time from the Trust Fund such amounts as the Secretary of Health, Education, and Welfare certifies are necessary to make the payments provided for by part B and the payments for administrative expenses in accordance with section 201(g)(1) of the Act.

SECTION 1842. USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

Section 1842(a) provides that in order to carry out the administration of the voluntary health insurance program established by part B, the Secretary to the extent possible will enter into contracts with carriers which will undertake to perform the functions specified in section 1842(a) or, to the extent provided in the contracts, to secure performance of such functions by other organizations.

Paragraph (1) of section 1842(a) provides that the carriers under contract (or such other organizations) will (A) make determinations of the rates and amounts of payments required pursuant to part B to be made to providers of services and other persons on a reasonable cost or reasonable charge basis, whichever applies; (B) receive, disburse, and account for funds in making such payments; and (C) make audits of the records of providers of services necessary to assure that proper payments are made to them under part B.

Paragraph (2) of section 1842(a) provides that the carriers will determine compliance with the requirements of section 1861(k) as to utilization review, and assist providers and other persons who furnish services for which payment may be made under part B in the development of procedures relating to utilization practices, make studies of the effectiveness of utilization procedures, assist in the application of safeguards against unnecessary utilization of services furnished by providers and other persons to individuals entitled to benefits under part B, and provide procedures for and assist in arranging, where necessary, the establishment of groups outside hospitals (meeting the requirements of section 1861(k)(2)) to make reviews of utilization.

Paragraph (3) of section 1842(a) provides that the carriers will serve as a channel of communication of information relating to the administration of the voluntary health insurance program under part B.

Paragraph (4) of section 1842(a) provides that the carriers will assist in discharging other necessary administrative duties, as may be provided in the contract.

Paragraph (1) of section 1842(b) provides that contracts with carriers under subsection (a) may be entered into without regard to section 3709 of the Revised Statutes or any other provision of law requiring competitive bidding.

Paragraph (2) of section 1842(b) provides that the Secretary is not to enter into a contract with a carrier unless he finds that the carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements relating to financial responsibility, legal authority, and other matters as he finds pertinent.

Paragraph (3) of section 1842(b) provides that each contract must provide that the carrier will—

(A) take necessary action to assure that, where payment under part B for a service is on a cost basis, the cost is reasonable cost (as determined under sec. 1861(v));

(B) take necessary action to assure that, where payment under part B for a service is on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier, and such payment will be made on the basis of a receipted bill, or on the basis of an assignment under which the reasonable charge is the full charge for the service;

(C) establish and maintain procedures under which an individual enrolled under part B will be entitled to a fair hearing by the carrier when request for payment is denied or is not acted upon with reasonable promptness or when the amount of payment is in controversy;

(D) furnish to the Secretary such timely information and reports as may be necessary for the Secretary to perform his functions under part B; and

(E) maintain and afford access to whatever records the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (D), and otherwise to carry out the purposes of part B.

Each contract shall also contain such other terms and conditions consistent with section 1842 as the Secretary may find necessary or appropriate.

Paragraph (4) of section 1842(b) provides that each contract must be for the term of at least 1 year, and may be made automatically renewable unless either party provides notice of intent to terminate the contract at the end of its current term. However, the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the carrier as he may provide in regulations) if he finds that the carrier has failed substantially to carry out the contract or is carrying it out in a manner inconsistent with the efficient and effective administration of the insurance program established by part B.

Section 1842(c) provides that each contract is to provide for advances of funds to the carrier for the making of payments by it under part B, and for payment of the necessary and proper administrative costs of the carrier.

Section 1842(d) provides that any contract may require a carrier or any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

Paragraph (1) of section 1842(e) provides that no individual designated pursuant to a contract as a certifying officer will, in the absence of gross negligence or intent to defraud the United States, be liable for any payments incorrectly certified by him.

Paragraph (2) of section 1842(e) provides a similar immunity for disbursing officers who make an incorrect payment based upon a voucher signed by a certifying officer designated as provided in paragraph (1).

Section 1842(f) provides that, for purposes of part B, the term "carrier" means (1) with respect to providers of services and other persons, a voluntary association, corporation, or partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization; and (2) with respect to providers of services only, any agency or organization (not described in (1)) with which an agreement is in effect under section 1816.

SECTION 1843. STATE AGREEMENTS FOR COVERAGE OF ELIGIBLE INDIVIDUALS WHO ARE RECEIVING MONEY PAYMENTS UNDER PUBLIC ASSISTANCE PROGRAMS

Section 1843(a) provides that the Secretary, at the request of a State made before July 1, 1967, will enter into an agreement with such State to provide coverage under part B for all eligible individuals who are in a coverage group elected by the State from the two groups described in section 1843(b). (For definition of "eligible individual" see section 1836, discussed above.)

Section 1843(b) provides that the agreement entered into with any State under section 1843(a) may be applicable to either of the following groups: (1) aged recipients of money payments under a plan of the State approved under title I or XVI, or (2) aged recipients of money payments under all of the plans of the State approved under titles I, IV, X, XIV, and XVI. However, neither group may include any individual entitled to monthly OASDI benefits or entitled to receive an annuity or pension under the Railroad Retirement Act of 1937.

Section 1843(c) provides that, for purposes of section 1843, coverage under the agreement may be provided only for an individual who is an eligible individual (as described above) on the date the agreement is entered into or who becomes an eligible individual in the period between the date of the agreement and July 1, 1967. He will be

treated as a money payment recipient if he receives a money payment for the month in which the agreement is entered into or any month between such month and July 1967.

Section 1843(d) provides that in the case of any individual enrolled pursuant to an agreement under section 1843—

(1) the monthly premium to be paid by the State is to be determined under section 1839 (without any increase under subsec. (c) thereof);

(2) his coverage period will begin either on July 1, 1966, on the first day of the third month following the month in which the State agreement is entered into, on the first day of the first month in which he is both an eligible individual and a member of the coverage group specified in the agreement, or on a date (not later than July 1, 1967) specified in the agreement, whichever is the latest; and

(3) his coverage period will end on either the last day of the month in which he is determined by the State to have become ineligible for the money payments specified in the agreement, or the last day of the month before the first month for which he becomes entitled to monthly benefits under title II or to an annuity or pension under the Railroad Retirement Act of 1937.

Section 1843(e) provides that any individual whose coverage period attributable to the State agreement is terminated (as described in sec. 1843(d)(3)) will be deemed for purposes of part B (including the continuation of his coverage period) to have enrolled under section 1837 in the initial general enrollment period (ending March 31, 1966) provided by section 1837(c).

Section 1843(f) provides that with respect to individuals receiving money payments under a State plan approved under title I, IV, X, XIV, or XVI, if the agreement so provides, the term "carrier" as defined in section 1842(f) also includes the State agency specified in the agreement which administers or supervises the administration of the State plan approved under title I, XVI, or XIX. Thus, a State agency which meets the definition of "carrier" under section 1843(f) could be considered a carrier with respect to all individuals receiving the specified money payments (including those who are not eligible to be in the coverage group as defined in sec. 1843(b) because they are entitled to monthly social security benefits or a pension or annuity under the railroad retirement system). The agreement with the State will also contain provisions to facilitate the financial transactions of the State and the carrier relating to deductions and coinsurance, in the interest of economy and efficiency of operation, with respect to individuals receiving money payments under the State's plans approved under titles I, IV, X, XIV, and XVI.

SECTION 1844. APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS AND CONTINGENCY RESERVE

Section 1844(a) authorizes the appropriation from time to time of a Government contribution, equal to the total premiums payable by individuals who have enrolled under part B, from the Treasury to the Federal Supplementary Health Insurance Benefits Trust Fund.

Section 1844(b) provides that in order to assure prompt payment of benefits and administrative expenses under part B during the early

months of the program, and to provide a contingency reserve, there is also authorized to be appropriated during the fiscal year ending June 30, 1966, for repayable advances (without interest) to the Trust Fund, an amount (to remain available through the next fiscal year) equal to \$18 multiplied by the number of individuals (as estimated by the Secretary) who could be covered in July 1966 by the insurance program established by part B if they had theretofore enrolled.

PART C—MISCELLANEOUS PROVISIONS

SECTION 1861. DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

Section 1861 defines, for purposes of both part A and part B, the terms used in the new title XVIII.

Spell of illness

Section 1861(a) defines the term “spell of illness” to mean a period of consecutive days (1) beginning with the first day (not included in a previous spell) on which the individual is furnished inpatient hospital or extended care services and which occurs in a month for which he is entitled to benefits under part A or B, and (2) ending with the close of the first period of 60 consecutive days thereafter throughout which he is neither an inpatient of a hospital nor an inpatient of an extended care facility. (For special definitions of “hospital” and “extended care facility” for purposes of sec. 1861(a)(2), see discussion of secs. 1861(e) and 1861(j) below.)

Inpatient hospital services

Section 1861(b) defines the term “inpatient hospital services” to mean the following items and services furnished to an inpatient of a hospital (and furnished by the hospital, except as provided in item (3)): (1) bed and board; (2) such nursing services, use of hospital facilities, medical social services, and drugs, biologicals, supplies, appliances, and equipment for use in the hospital as are ordinarily furnished by such hospital for the care and treatment of inpatients; (3) other diagnostic or therapeutic items or services ordinarily furnished by the hospital or by others under arrangements made by the hospital. Excluded from the term “inpatient hospital services” are the services of a private-duty nurse or attendant and medical or surgical services provided by a physician, resident, or intern; except that services of a resident-in-training or intern provided under a teaching program approved by the American Medical Association or the American Osteopathic Association are included in the term.

Inpatient psychiatric hospital services

Section 1861(c) defines the term “inpatient psychiatric hospital services” to mean inpatient hospital services furnished to an inpatient of a psychiatric hospital.

Inpatient tuberculosis hospital services

Section 1861(d) defines the term “inpatient tuberculosis hospital services” to mean inpatient hospital services furnished to an inpatient of a tuberculosis hospital.

Hospital

Section 1861(e) defines the term "hospital" to mean in general an institution which (1) is primarily engaged in providing diagnostic and therapeutic services for medical diagnosis, treatment, and care, or rehabilitation services for injured, disabled, or sick persons; (2) maintains clinical records on all patients; (3) has bylaws in effect with respect to its staff of physicians; (4) requires that every patient be under the care of a physician; (5) provides 24-hour nursing service rendered by or under the supervision of a registered nurse; (6) has in effect a hospital utilization review plan satisfying section 1861(k); (7) is licensed (or meets standards of licensing) pursuant to State or local law; and (8) meets such other requirements as the Secretary finds necessary in the interest of health and safety (except that these requirements may not be higher than the comparable requirements prescribed for accreditation of hospitals by the Joint Commission on Accreditation of Hospitals).

For the specific purpose of determining how long an individual is out of a hospital in order to establish when a spell of illness ends, an institution satisfying item (1) of the definition is a "hospital." In determining whether emergency hospital services are covered under section 1814(d), and for purposes of describing the institution from which an individual must be transferred in order to be eligible for post-hospital extended care or post-hospital home health services, an institution satisfying items (1), (2), (3), (4), (5), and (7) of the definition is a "hospital." The term "hospital" does not (except for purposes of determining when a spell of illness ends) include any institution which is primarily for the care and treatment of mental diseases or tuberculosis, except that for purposes of part A the term includes a tuberculosis hospital as defined in section 1861(g) and for purposes of part B the term includes a psychiatric hospital as defined in section 1861(f). The term also includes a Christian Science sanatorium operated or listed and certified by the First Church of Christ Scientist, Boston, Mass., but payment may be made with respect to services provided by or in such a sanatorium only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of those otherwise applicable) as may be provided in regulations.

Psychiatric hospital

Section 1861(f) defines the term "psychiatric hospital" to mean an institution which (1) is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons; (2) satisfies the requirements prescribed for hospitals under items (3) through (8) of section 1861(e); (3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals enrolled under the insurance program established by part B; (4) meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution; and (5) is accredited by the Joint Commission on Accreditation of Hospitals. If an institution satisfies requirements (1) and (2) and contains a distinct part which also satisfies requirements (3) and (4), the distinct part will

be considered to be a "psychiatric hospital" if the institution is accredited by the Joint Commission on Accreditation of Hospitals or the distinct part satisfies requirements equivalent to the accreditation requirements of the Joint Commission as determined by the Secretary.

Tuberculosis hospital

Section 1861(g) defines the term "tuberculosis hospital" to mean an institution which (1) is primarily engaged in providing, by or under the supervision of a physician, medical services for the diagnosis and treatment of tuberculosis; (2) satisfies the requirements prescribed for hospitals under items (3) through (8) of section 1861(e); (3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals covered under the insurance program established by part A; (4) meets such staffing requirements as the Secretary may find necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution; and (5) is accredited by the Joint Commission on Accreditation of Hospitals. If an institution satisfies requirements (1) and (2) and contains a distinct part which also satisfies requirements (3) and (4), the distinct part will be considered to be a "tuberculosis hospital" if the institution is accredited by the Joint Commission on Accreditation of Hospitals or the distinct part satisfies requirements equivalent to the accreditation requirements of the Joint Commission as determined by the Secretary.

Extended care services

Section 1861(h) defines the term "extended care services" to mean the following items and services furnished to an inpatient of an extended care facility (and furnished by such facility except as provided in items (3) and (6)): (1) nursing care furnished by or under the supervision of a registered nurse; (2) bed and board; (3) physical, occupational, or speech therapy furnished by the facility or others under arrangements with them; (4) medical social services; (5) such drugs, biologicals, supplies, appliances, and equipment as are ordinarily furnished by the facility for care and treatment of inpatients; (6) medical services of interns and residents-in-training under an approved teaching program of a hospital with which such facility has in effect a transfer agreement and certain other services provided by such a hospital; and (7) such other health services as are generally provided by extended care facilities. Any service which would not be covered if furnished to an inpatient of a hospital is excluded.

Post-hospital extended care services

Section 1861(i) defines the term "post-hospital extended care services" to mean extended care services (as defined in sec. 1861(h)) furnished an individual after transfer from a hospital of which he was an inpatient for not less than 3 consecutive days before his discharge. Items and services will be deemed to have been furnished to an individual after transfer from a hospital, and he will be deemed to have been an inpatient of the hospital immediately before transfer, if he is admitted to the extended care facility within 14 days after discharge from such hospital. An individual will be deemed not to have been discharged from an extended care facility if he is readmitted to such facility within 14 days after discharge therefrom.

Extended care facility

Section 1861(j) defines the term "extended care facility" to mean an institution (or a distinct part thereof) which has a transfer agreement with one or more participating hospitals (as described in sec. 1861(l)) and which (1) is primarily engaged in providing to inpatients skilled nursing care and related services, or rehabilitation services; (2) has policies which are developed with the advice of and periodically reviewed by a professional group (including at least one physician and at least one registered nurse) to govern the services it provides; (3) has a physician, registered nurse, or medical staff responsible for the execution of such policies; (4) requires that the health care of each patient be under the supervision of a physician and provides for having a physician available to furnish necessary emergency medical care; (5) maintains clinical records on all patients; (6) provides 24-hour nursing services sufficient to meet needs in accordance with facility policies and has at least one registered professional nurse employed full time; (7) provides appropriate methods for dispensing and administering drugs and biologicals; (8) has in effect a utilization review plan satisfying section 1861(k); (9) is licensed (or meets the standards for licensing) pursuant to State or local law; and (10) meets such other conditions relating to health and safety or physical facilities as the Secretary may find necessary. The term "extended care facility" does not include any institution which is primarily for the care and treatment of mental diseases or tuberculosis. For the specific purpose of determining when a spell of illness ends (under sec. 1861(a)(2)) the term includes any institution which satisfies item (1).

Utilization review

Section 1861(k) provides that a utilization review plan of a hospital or extended care facility will be considered sufficient if it is applicable to services furnished to individuals entitled to benefits under part A or part B and if it provides (1) for the review, on a sample or other basis, of admissions, duration of stays, and professional services from the standpoint of medical necessity and for the purpose of promoting the most efficient use of available health facilities and services; (2) for such review to be made by a staff committee of the institution which includes two or more physicians, or by a similarly composed group outside the institution which is established either by the local medical society and some or all of the hospitals and extended care facilities in the locality or in some other manner which may be approved by the Secretary; (3) for such review (in each case of a continuous stay of extended duration in a hospital or extended care facility) as of such days of such stay (which may be different for different classes of cases) as may be specified in regulations, with such review being made as promptly as possible after each day specified in the regulations but no later than 1 week following that day; and (4) for prompt notification to the institution, the individual, and his physician of any finding (which shall be made only after opportunity for consultation has been provided the physician) that further stay in the institution is not medically necessary. The utilization review plan must provide for review by a group outside the institution where, because of its small size (or, in the case of an extended care facility, because of lack of an organized medical staff), or for such other reasons

as may be included in regulations, it is impracticable for the institution to have a properly functioning staff committee.

Agreements for transfer between extended care facilities and hospitals

Section 1861(l) provides that a hospital and an extended care facility will be considered to have a transfer agreement if a written agreement between them (or a written undertaking by the person or body controlling them, in the case of institutions under common control) provides reasonable assurance that (1) there will be timely transfer of patients between the institutions whenever it is determined medically appropriate by the attending physician; and (2) there will be timely transfer between the institutions of medical and other information needed for patients' care or for determining whether patients can be adequately cared for in some other way. Any extended care facility which does not have a transfer agreement in effect, but which is found by a State agency (with which an agreement under sec. 1864 is in effect) or by the Secretary (if there is no such agreement) to have attempted in good faith to enter into such an agreement with a hospital close enough to the facility to make transfer of patients and information between them feasible, will be considered to have a transfer agreement in effect if the agency (or the Secretary) finds that to do so is in the public interest and essential to assuring extended care services for persons in the community who are eligible for benefits under title XVIII.

Home health services

Section 1861(m) defines the term "home health services" to mean the following items and services furnished to an individual who is under the care of a physician, on a visiting basis in his residence (except as provided in item (7)), by a home health agency (or by others under arrangements with such agency) under a plan established and periodically reviewed by a physician: (1) part-time or intermittent nursing care provided by or under the supervision of a registered nurse; (2) physical, occupational, or speech therapy; (3) medical social services under the direction of a physician; (4) to the extent permitted in regulations, part-time or intermittent home health aide services; (5) medical supplies (other than drugs and biologicals) and the use of medical appliances; (6) medical services of interns and residents-in-training under an approved teaching program of a hospital with which the agency is affiliated; and (7) any of the foregoing items and services which (A) are provided on an outpatient basis under arrangements made by the home health agency at a hospital or extended care facility, or at a rehabilitation center meeting such standards as may be prescribed in regulations, and (B) involve the use of equipment of such nature that the items and services cannot readily be made available to the individual in his place of residence, or are furnished at such facility while he is there to receive any item or service involving the use of such equipment (but excluding transportation of the individual in connection with such items or services). Any item or service which would not be covered if furnished to an inpatient of a hospital is excluded.

Post-hospital home health services

Section 1861(n) defines the term "post-hospital home health services" to mean home health services (as defined in sec. 1861(m)) which

(1) are furnished an individual within 1 year after his most recent discharge from a hospital of which he was an inpatient for not less than 3 consecutive days or (if later) within 1 year after his most recent discharge from an extended care facility of which he was an inpatient entitled to benefits under part A, and (2) are covered by a plan (described above) established within 14 days after his discharge from the hospital or extended care facility.

Home health agency

Section 1861(o) defines the term "home health agency" to mean a public agency or private organization (or a part of such agency or organization) which (1) primarily provides skilled nursing or other therapeutic services; (2) has policies established by a professional group (including at least one physician and at least one registered nurse) to govern services, and provides for supervision of such services by a physician or a registered nurse; (3) maintains clinical records on all patients; (4) is licensed (or meets standards for licensing) pursuant to State or local law; and (5) meets other conditions found by the Secretary to be necessary for health and safety. The term does not include a private organization which is not a nonprofit organization exempt from Federal income taxation unless it is licensed pursuant to State law and meets such additional standards and requirements as may be prescribed by regulations. For purposes of part A, the term does not include any agency or organization which is primarily for the care and treatment of mental diseases.

Outpatient hospital diagnostic services

Section 1861(p) defines the term "outpatient hospital diagnostic services" to mean diagnostic services which are ordinarily furnished to outpatients for purposes of diagnostic study by the hospital or by others under arrangements made by the hospital, and which are furnished in facilities supervised by the hospital or its organized medical staff. The term excludes any services which would not be covered if furnished to an inpatient of a hospital.

Physicians' services

Section 1861(q) defines the term "physicians' services" to mean professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls (but not services provided by an intern or resident-in-training under a teaching program approved as described in sec. 1861(b)).

Physician

Section 1861(r) defines the term "physician" to mean an individual legally authorized by a State to practice medicine and surgery (including osteopathy).

Medical and other health services

Section 1861(s) defines the term "medical and other health services" to mean any of the following items or services (unless such services are otherwise classified as inpatient hospital, extended care, home health, or physicians' services): (1) diagnostic X-ray and laboratory tests, electrocardiograms, basal metabolism readings, electroencephalograms, and other diagnostic tests; (2) X-ray, radium, and radioactive isotope therapy, including materials and services of technicians; (3) surgical

dressings, and splints, casts, and other devices used for reduction of fractures and dislocations; (4) rental of durable medical equipment, including iron lungs, oxygen tents, hospital beds, and wheelchairs used in the patient's home (including an institution used as the patient's home); (5) ambulance service where the use of other methods of transportation is contraindicated by the individual's condition (but only to the extent provided in regulations); (6) prosthetic devices (other than dental) which replace all or part of an internal body organ (including replacement of such devices); and (7) leg, arm, back, and neck braces, and artificial legs, arms, and eyes (including replacements if required because the patient's physical condition changes).

Drugs and biologicals

Section 1861(t) defines the term "drugs" and the term "biologicals" to mean (except for purposes of the exclusion of drugs and biologicals under home health services) those drugs and biologicals which are included in the United States Pharmacopoeia or the National Formulary, or in New Drugs or Accepted Dental Remedies (except for any drugs and biologicals unfavorably evaluated therein), or which are approved by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of the hospital furnishing them.

Provider of services

Section 1861(u) defines the term "provider of services" to mean a hospital, extended care facility, or home health agency.

Reasonable cost

Paragraph (1) of section 1861(v) provides that the reasonable cost of any services is to be determined under regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies the amount of the payment determined under such paragraph with respect to the services involved will be considered the reasonable cost of such services. In prescribing these regulations the Secretary must consider, among other things, the principles developed and generally applied by national organizations or established prepayment organizations in computing the amount of payment to be made by third parties to providers of services on account of services furnished to individuals by such providers. Such regulations may provide for determination of the cost of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations must take into account both direct and indirect costs of providers in order that the costs with respect to individuals covered by the insurance programs established by title XVIII will not be borne by individuals not so covered and the costs with respect to individuals not covered will not be borne by the insurance programs. The regulations must also provide for making retroactive corrective adjustments where, for any provider of services for any fiscal period, the total reimbursement produced by methods of determining costs proves to be either inadequate or excessive.

Paragraph (2) of section 1861(v) provides that if a patient receives inpatient services in accommodations which are more expensive than semiprivate accommodations, but which are not medically necessary, the amount of payment may not exceed an amount equal to the reasonable cost of such services if furnished in semiprivate accommodations. If a patient receives other items or services which are more expensive than those for which payment can be made, the Secretary will take into account for purposes of payment no more than the reasonable cost of the services that can be paid for.

Paragraph (3) of section 1861(v) provides that if a patient is placed in accommodations less expensive than semiprivate accommodations for a reason the Secretary determines is not consistent with the program's purpose (and not at the patient's request), payment will be limited to the reasonable cost of semiprivate accommodations minus the difference between the customary charges for semiprivate accommodations and the accommodations furnished.

Paragraph (4) of section 1861(v) defines the term "semiprivate accommodations" to mean two-bed, three-bed, or four-bed accommodations.

Arrangements for certain services

Section 1861(w) provides that the term "arrangements" is limited to arrangements under which receipt of payment by a participating provider of services discharges all financial liability for the services.

State and United States

Section 1861(x) provides that the terms "State" and "United States" have the same meaning as when used in title II of the Social Security Act (i.e., the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa).

SECTION 1862. EXCLUSIONS FROM COVERAGE

Section 1862(a) provides that no payment may be made under part A or part B (regardless of any other provision of title XVIII) for any expenses incurred for items or services (1) which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member; (2) for which the individual furnished such items or services has no legal obligation to pay and which no other person (because of such individual's membership in a prepayment plan or for some other reason) has a legal obligation to provide or to pay for; (3) which are paid for directly or indirectly by a governmental entity (other than under the Social Security Act), except in such cases as the Secretary may specify; (4) which are not provided within the United States; (5) which are required as a result of war, or of an act of war, occurring after the effective date of such individual's current coverage under such part; (6) which constitute personal comfort items; (7) where such expenses are for routine physical checkups, eyeglasses or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses (including contact lenses), hearing aids or examinations therefor, or immunizations; (8) where such expenses are for orthopedic shoes or other supportive devices for the feet; (9) where such expenses are for custodial care; (10) where such expenses are for cosmetic surgery or are incurred

in connection therewith, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member; or (11) where such expenses constitute charges imposed by immediate relatives of the individual or members of his household.

Section 1862(b) provides that no payment may be made under part A or part B for any item or service for which payment has been made, or can reasonably be expected to be made, under a workmen's compensation law or plan of the United States or a State. Any payment under part A or part B with respect to any item or service must be conditioned on reimbursement being made to the appropriate Trust Fund for such payment if and when notice or other information is received that payment for such item or service has been made under such a law or plan.

SECTION 1863. CONSULTATION WITH STATE AGENCIES AND OTHER ORGANIZATIONS TO DEVELOP CONDITIONS OF PARTICIPATION FOR PROVIDERS OF SERVICES

Section 1863 provides that the Secretary is to consult with the Health Insurance Benefits Advisory Council (established by sec. 1867), appropriate State agencies, and national listing or accrediting bodies, and may consult with local agencies, in prescribing such conditions for participation for providers of services as may be necessary for health and safety. The conditions may be varied for different areas or classes of institutions, and may be set higher for the institutions or agencies in a particular State at such State's request (but, in the case of hospitals, not higher than the accreditation requirements of the Joint Commission on Accreditation of Hospitals).

SECTION 1864. USE OF STATE AGENCIES TO DETERMINE COMPLIANCE BY PROVIDERS OF SERVICES WITH CONDITIONS OF PARTICIPATION

Section 1864(a) provides that the Secretary is to make an agreement with any State which is able and willing to enter into an agreement to utilize the services of the State health agency or other appropriate State agencies (or the appropriate local agencies) for the purpose of determining which institutions and agencies qualify to participate in the programs under title XVIII. The Secretary may accept a State (or local) agency's findings as to the qualifications of an institution or agency to participate. The Secretary may also, pursuant to agreement, use State and local agencies to do any of the following: (1) provide consultative services to institutions or agencies to assist them in establishing and maintaining fiscal records or otherwise qualifying for participation, or in providing information necessary to determine what benefits are payable; and (2) provide consultative services to institutions, agencies, or organizations to assist them in establishing and evaluating the effectiveness of utilization review procedures.

Section 1864(b) provides that the Secretary is to pay the State for the reasonable costs of the administrative activities performed under its agreement under section 1864(a), and for the Federal Hospital Insurance Trust Fund's fair share of the costs attributable to planning and other efforts directed toward coordination of activities in carrying out its agreement and other activities related to the provision of

services similar to those for which payment may be made under part A, or related to the facilities and personnel required for the provision of such services, or related to improving the quality of such services.

SECTION 1865. EFFECT OF ACCREDITATION

Section 1865 provides that any hospital accredited by the Joint Commission on Accreditation of Hospitals will be deemed to meet all the requirements in the definition of "hospital" in section 1861(e) except the utilization review requirement. If the Joint Commission requires a utilization review plan (or imposes another requirement serving the same purpose) for accreditation, the Secretary is authorized to find that accredited hospitals meet all the requirements in such definition. The Secretary may also accept the findings of the American Osteopathic Association, or any other national accrediting body, as to the eligibility of institutions and agencies to participate if he finds reasonable assurance that the pertinent requirements of section 1861 are met.

SECTION 1866. AGREEMENTS WITH PROVIDERS OF SERVICES

Paragraph (1) of section 1866(a) provides that any provider of services will be eligible to participate and eligible for payments under title XVIII if it files an agreement with the Secretary not to charge for covered services (except as provided in paragraph (2)) and to make adequate provision for refund of erroneous charges.

Paragraph (2) of section 1866(a) provides that a provider of services may charge an individual the following: (A) the amount of any deductible imposed pursuant to section 1813(a)(1) or (a)(2) or section 1833(b), and in addition an amount equal to 20 percent of the reasonable charges for the items and services furnished (not in excess of 20 percent of the amount customarily charged for such items and services by the provider) for which payment is made under part B (except that, in the case of expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital, the provider may charge the proportion which is appropriate under the limits imposed by sec. 1833(c)); (B) the excess amount of more expensive services and items furnished at the request of the individual; and (C) the cost of the first 3 pints of whole blood furnished during a spell of illness; except that a charge may not be made for the cost of the administration of such blood and no charge can be made if the blood has been replaced on the individual's behalf or arrangements have been made for its replacement. To illustrate the latter provision (taken together with the provisions of secs. 1813(a)(3) and 1833(d)): if a hospital were to charge a beneficiary \$25 for a pint of blood which cost the hospital \$10 (and which was 1 of the first 3 pints of blood furnished the beneficiary in the spell of illness), the program would not pay the hospital the \$10 cost of the blood but there would be deducted from payments otherwise due the hospital the difference between the \$10 cost and the \$25 charge—i.e., \$15; thus, if the hospital collected the \$25 from the beneficiary, the hospital would receive no more in payments from the patient and the program than if it had charged the beneficiary only the \$10 cost of the blood.

Section 1866(b) provides that an agreement with a provider of services under section 1866(a) may be terminated by the provider at such time and upon such public notice as may be prescribed by regulations. The Secretary could require the agreement to remain in effect for up to 6 months after the provider gives notice. The Secretary may terminate such an agreement if he determines that the provider (A) is not complying with the agreement or the law, (B) is no longer qualified to participate, or (C) has failed to provide data to determine whether payments are due the provider or the amount of such payments, or has refused access to its records for verification. The termination of any agreement with a provider is to be applicable with respect to (1) inpatient hospital services (including inpatient tuberculosis hospital services), inpatient psychiatric hospital services, and post-hospital extended care services furnished to an individual admitted on or after the effective date of termination, (2) home health services furnished under a plan established on or after the effective date of termination or, if the plan is established before the effective date, services furnished after the calendar year in which the termination is effective, and (3) any other items or services furnished on or after the effective date of termination.

Section 1866(c) provides that if the Secretary terminates an agreement, the provider may not file a new agreement unless the Secretary finds that the reason or reasons for termination is or are removed and that there is assurance they will not recur.

Section 1866(d) provides that if the Secretary finds that timely reviews of long-stay cases are not being made by a hospital or extended care facility he may, in lieu of terminating the agreement, deny payment for services furnished an individual after the 20th day of continuous inpatient hospital care or after stays of a prescribed length in an extended care facility. Such a decision denying payment for services may be made only after notice to the provider and the public and will be rescinded when the Secretary finds that the reviews are being made and that there is assurance they will continue to be made. The Secretary may not make any decision denying such payment except after reasonable notice and opportunity for hearing.

SECTION 1867. HEALTH INSURANCE BENEFITS ADVISORY COUNCIL

Section 1867 provides for the creation of a Health Insurance Benefits Advisory Council to advise the Secretary on general policy in the administration of title XVIII and in the formulation of regulations thereunder. The Council is to consist of 16 persons, who are not Federal employees, to be appointed by the Secretary. The Secretary will from time to time appoint one of the members to serve as Chairman. The Council is to include people who are outstanding in fields related to hospital, medical, and other health activities, and at least one person who is representative of the general public. The members are to serve 4-year terms and may not serve continuously for more than 2 consecutive terms. The Secretary may appoint such special advisory professional or technical committees as may be useful. The Council members and members of any advisory or technical committee will be entitled to receive compensation at rates fixed by the Secretary (not exceeding \$100 a day). The Council is to meet as frequently as the Secretary finds necessary, but he must call a meeting upon request of 4 members.

SECTION 1868. NATIONAL MEDICAL REVIEW COMMITTEE

Section 1868(a) provides for the creation of a National Medical Review Committee. The Committee is to consist of 9 persons, who are not Federal employees, to be appointed by the Secretary. The members are to be selected from among representatives of organizations and associations of professional personnel in the field of medicine and other individuals who are outstanding in the field of medicine or in related fields; at least one member must be representative of the general public and a majority of the members must be physicians. The members are to hold office for 3-year terms and may not serve continuously for more than 2 terms.

Section 1868(b) provides that the Committee members will be entitled to receive compensation at rates fixed by the Secretary (not exceeding \$100 a day).

Section 1868(c) provides that it is the Committee's function to study the utilization of hospital and other medical care and services for which payment can be made under part A or part B with a view to recommending any changes which may seem desirable in the utilization of care and services or the administration of the programs, or in the provisions of title XVIII. The Committee is to make to the Secretary (who is to transmit it promptly to the Congress) an annual report including any recommendations the Committee may have.

Section 1868(d) authorizes the Committee to engage any technical assistance required to carry out its functions. It also provides that the Secretary is to make available the secretarial, clerical, and other assistance and data needed by the Committee.

SECTION 1869. DETERMINATIONS; APPEALS

Section 1869(a) provides that determinations of entitlement to benefits under part A and part B, and of the amount of benefits under part A, are to be made by the Secretary in accordance with regulations.

Section 1869(b) provides that any individual dissatisfied with any determination under section 1869(a) as to entitlement under part A or part B, or as to amount of benefits under part A if the matter in controversy is \$1,000 or more, will be entitled to the same hearing and appeal procedures as are now provided in sections 205(b) and 205(g) of the Act.

Section 1869(c) provides that any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination terminating an agreement under section 1866(b)(2), will be entitled to the same hearing and appeal procedures as are now provided in sections 205(b) and 205(g).

SECTION 1870. OVERPAYMENTS ON BEHALF OF INDIVIDUALS

Section 1870(a) provides that any payment under part A or part B to a provider of services for services furnished an individual will be considered as a payment to such individual.

Section 1870(b) provides that where overpayment is made to a provider of services or other person and cannot be recouped from such provider or person, or payment is made under the conditions specified in section 1814(e) or 1835(c) for an individual who is not

entitled to have such payment made, subsequent cash social security benefits or railroad retirement benefits payable to the individual (or, if such individual dies, benefits payable to others based on his earnings) will be reduced in accordance with regulations prescribed by the Secretary after consultation with the Railroad Retirement Board. As soon as practicable after any such adjustment is determined to be necessary, the Secretary (for purposes of sec. 1870 and secs. 1817(g) and 1841(f)) will certify (to the Railroad Retirement Board if adjustment is to be made by decreasing cash payments under the Railroad Retirement Act of 1937) the amount of the overpayment with respect to which the adjustment is to be made.

Section 1870(c) provides there will be no adjustment (or recovery) in any case in which the individual is without fault, or in which the adjustment (or recovery) would defeat the purposes of title II of the act or would be against equity and good conscience.

Section 1870(d) provides that no certifying or disbursing officer will be liable for overpayments where adjustment or recovery is waived or is not completed prior to the death of all persons against whose benefits the adjustment is authorized.

SECTION 1871. REGULATIONS

Section 1871 provides that the Secretary will prescribe the regulations necessary to carry out the administration of the new insurance programs under title XVIII. When used in such title the term "regulations" means (unless the context otherwise requires) regulations prescribed by the Secretary.

SECTION 1872. APPLICATION OF CERTAIN PROVISIONS OF TITLE II

Section 1872 provides that sections 206, 208, 216(j), and 205 (a), (d), (e), (f), (h), (i), (j), (k), and (l) of the act will apply to title XVIII as they do to title II.

SECTION 1873. DESIGNATION OF ORGANIZATION OR PUBLICATION BY NAME

Section 1873 provides that any designation made in title XVIII, by name, of any nongovernmental organization or publication will not be affected by a change of the name of such organization or publication and will apply to any successor organization or publication which the Secretary finds serves the purpose for which the designation was made.

SECTION 1874. ADMINISTRATION

Section 1874(a) provides that, except as otherwise stated, the programs established by title XVIII are to be administered by the Secretary, who may perform any of his functions directly or by contract.

Section 1874(b) provides that the Secretary may contract with any person, agency, or institution to secure such special data and actuarial and other information as may be necessary in carrying out his functions.

SECTION 1875. STUDIES AND RECOMMENDATIONS

Section 1875(a) provides that the Secretary is to make studies and develop recommendations to be submitted to the Congress relating to the health care of the aged, including studies and recommendations concerning the adequacy of existing personnel and facilities for health care for purposes of the programs under title XVIII; methods for encouraging further development of efficient and economical alternatives to inpatient hospital care; the effect of the deductibles and coinsurance provisions upon beneficiaries, providers of health services, and the financing of the program; and the desirability of broadening or modifying the provisions which authorize payment for additional days of post-hospital extended care services where the maximum number of days of inpatient hospital services in a spell of illness has not been used.

Section 1875(b) instructs the Secretary to make a continuing study of the operation and administration of the insurance programs under title XVIII and to submit to the Congress annually a report concerning the operation of such programs.

SECTION 102. HOSPITAL INSURANCE BENEFITS AND
SUPPLEMENTARY HEALTH INSURANCE BENEFITS—
(Continued)

Section 102(b) of the bill provides that if an individual was eligible to enroll under the supplementary health insurance program under part B of the new title XVIII before April 1, 1966, but failed to do so before such date, and it is shown to the satisfaction of the Secretary that there was good cause for such failure to enroll, such individual may enroll in the supplementary health insurance program at any time before October 1, 1966. The Secretary will by regulation determine what constitutes good cause. The coverage period (within the meaning of sec. 1838 of the Social Security Act) of an individual enrolling under this provision will begin on the first day of the 6th month after the month in which he enrolls.

SECTION 103. TRANSITIONAL PROVISION ON ELIGIBILITY
OF PRESENTLY UNINSURED INDIVIDUALS FOR HOS-
PITAL INSURANCE BENEFITS

Section 103(a) of the bill provides that anyone who—

(1) has attained age 65 before 1968 (or has earned 3 quarters of coverage for each calendar year after 1965 and before the year of attainment of age 65);

(2) is not entitled to hospital insurance benefits (and would not be entitled to such benefits upon filing application for monthly benefits under section 202 of the Social Security Act), and is not certifiable as a qualified railroad retirement beneficiary (see sec. 105 of the bill, discussed below);

(3) is a resident of the United States, and is a citizen (or has resided in the United States continuously for at least 10 years immediately prior to the month in which he files application under section 103); and

(4) has filed an application under section 103 in accordance with regulations, will be entitled to benefits under part A of title XVIII beginning with the first month in which he meets these requirements and ending with the month he dies or, if earlier, the month before the month in which he becomes eligible for hospital insurance benefits under section 226 or becomes certifiable as a railroad retirement beneficiary.

Any person who would have met the preceding requirements in any month if he had filed an application before the end of that month will be deemed to have met such requirements for that month if he files an application before the end of the next 12 months. No application will be accepted as a valid application under section 103 if it is filed before the first month in which the individual meets the requirements of paragraphs (1), (2), and (3) above; i.e., an application filed prematurely will not prevent the individual from obtaining benefits under section 103 if he qualifies therefor at a later time.

Section 103(b) of the bill provides that section 103(a) does not apply to any person who (as of the time of his application under such section) (1) is a member of any organization referred to in section 210(a)(17) of the Social Security Act (relating to subversive organizations); (2) has been convicted of any offense listed in section 202(u) of such act; or (3) is eligible, or could have been eligible if he or some other person had taken the appropriate action, for benefits under the Federal Employees Health Benefits Act of 1959.

Section 103(c) authorizes the appropriation to the Federal Hospital Insurance Trust Fund of such sums as the Secretary deems necessary on account of payments made under part A of title XVIII of the Social Security Act to individuals who are entitled to benefits thereunder solely by reason of section 103 of the bill and on account of the additional administrative expenses and loss of interest to the Fund resulting from such payments.

SECTION 104. SUSPENSION IN CASE OF ALIENS; PERSONS CONVICTED OF SUBVERSIVE ACTIVITIES

Paragraph (1) of section 104(a) of the bill amends section 202(t) of the Social Security Act (relating to suspension of benefits for certain aliens outside the United States) by adding a new paragraph which provides that an individual is not entitled to benefits under part A of title XVIII for any month for which his cash social security benefits are suspended under such section.

Paragraph (2) of section 104(a) of the bill amends section 202(u) of the Social Security Act so that the penalty which may be imposed thereunder upon a conviction for subversive activities (namely, the elimination of all earnings credits for the calendar quarter in which the conviction occurs and prior quarters) will apply to a determination of entitlement to benefits under part A of title XVIII, as well as to the determination of entitlement to cash benefits under title II as provided in existing law.

Paragraph (1) of section 104(b) of the bill provides that payments may not be made under part B of title XVIII for expenses incurred by an individual for any month for which he may not be paid cash benefits under title II by reason of section 202(t) (relating to suspension of benefits for certain aliens who are outside the United States).

Paragraph (2) of section 104(b) of the bill provides that an individual convicted of any of the offenses stipulated in section 202(u) of the Social Security Act may not enroll under part B of title XVIII.

SECTION 105. RAILROAD RETIREMENT AMENDMENTS

Paragraph (1) of section 105(a) of the bill adds a new section 21 to the Railroad Retirement Act of 1937 to provide that, in order to make available hospital insurance benefits under part A of title XVIII of the Social Security Act (added by sec. 102 of the bill) for annuitants, pensioners, and certain other aged individuals under the railroad retirement system, the Railroad Retirement Board is to certify to the Secretary of Health, Education, and Welfare, upon the Secretary's request, the name of any individual who has attained age 65 and—

(1) is entitled to an annuity or pension under the Railroad Retirement Act, or

(2) would be entitled to an annuity under such act if he (or, in the case of a spouse, the spouse's husband or wife) had stopped working in employment covered under such act and applied for such annuity, or

(3) bears a relationship to an employee which by reason of section 3(e) of such act (providing a minimum for the amounts of railroad retirement annuities which is based on the social security benefit formula) has been, or would be, taken into account in calculating the amount of the annuity of such employee or his survivors.

The certification made by the Board to the Secretary of Health, Education, and Welfare is to include such additional information as may be necessary to carry out the hospital insurance benefit provisions, and will be effective on the date of certification or on such earlier date (not more than 1 year prior to the date of certification) as the Board specifies as the date on which the individual first met the requirements for certification. The Board is to notify the Secretary of the date on which the individual no longer meets the requirements.

Paragraph (2) of section 105(a) of the bill provides that, for purposes of section 21 of the Railroad Retirement Act of 1937 (and secs. 1840, 1843, and 1870 of the Social Security Act), entitlement to an annuity or pension under the Railroad Retirement Act of 1937 is deemed to include entitlement under the Railroad Retirement Act of 1935.

Section 105(b) of the bill amends sections 3201, 3211, and 3221(b) of the Railroad Retirement Tax Act (ch. 22 of the Internal Revenue Code of 1954), relating to the rate of tax on employees, on employee representatives, and on employers, respectively. The amendments change the references to section 3101 of the Code in those sections to section 3101(a) to conform to the amendment to section 3101 made by section 321(b) of the bill. A clarifying change is made in each such section by adding a specific reference to the rate of tax (2¼ percent) provided under the Social Security Amendments of 1956. The amendments made by section 105(b) are effective with respect to compensation for services rendered after December 31, 1965.

Section 105(c) of the bill contains a cross reference to section 326 of the bill, which amends the Railroad Retirement Act of 1937 to preserve the existing relationship between the railroad retirement and old-age, survivors, and disability insurance systems.

SECTION 106. MEDICAL EXPENSE DEDUCTION

Allowance of deduction

Section 106(a) of the bill amends section 213(a) of the Internal Revenue Code of 1954 (relating to allowance of deduction for medical expenses).

Under existing law, the general rule is that a taxpayer may deduct expenses for the medical care of himself, his spouse, and his dependents; but only to the extent that they exceed 3 percent of adjusted gross income. The 3-percent limitation is not applicable, however, in the case of expenses paid by the taxpayer (1) for the medical care of a dependent mother or father of the taxpayer or his spouse, if such mother or father has attained the age of 65 before the close of the taxable year, or (2) for the medical care of the taxpayer or his spouse if either has attained the age of 65 before the close of the taxable year.

Section 106(a) of the bill revises section 213(a) by dividing it into two paragraphs, each of which describes a separate part of the total medical expense deduction allowable.

3-percent limitation

Under paragraph (1) of section 213(a), as amended by the bill, the taxpayer (regardless of age) may deduct expenses for the medical care of himself, his spouse, and his dependents only to the extent that such expenses exceed 3 percent of adjusted gross income. The 3-percent limitation is applicable to the expenses for the taxpayer, his spouse, and his dependents whether or not the taxpayer, his spouse, or his dependents have attained the age of 65 before the close of the taxable year. In determining the amount deductible under paragraph (1) of section 213(a) (that is, the amount subject to the 3-percent limitation), there is excluded the amount deductible under the revised paragraph (2) with respect to expenses paid for insurance which constitutes medical care.

Insurance constituting medical care

Under paragraph (2) of section 213(a), as amended by the bill, the taxpayer may deduct an amount equal to one-half of the expenses paid during the taxable year for insurance which constitutes medical care (as such term is defined in section 213(e) as amended by section 106(c) of the bill) for the taxpayer, his spouse, or a dependent. The maximum amount deductible under paragraph (2) is \$250.

Example.—Assume that A has medical care expenses for the year (excluding amounts paid for medical care insurance) of \$800 which are for himself and his spouse; that A has paid during the year \$600 for insurance which constitutes medical care for himself and his spouse; and that A has adjusted gross income of \$5,000. A's deduction under the new section 213(a)(2) is \$250 (one-half of \$600 but not in excess of \$250). His deduction under section 213(a)(1) is \$1,000 (whether or not A or his spouse is age 65) computed as follows:

Total medical care expenses (including insurance).....	\$1, 400
Less: Expenses for insurance deductible under sec. 213(a)(2).....	250
	<hr/>
	1, 150
Less: 3 percent of adjusted gross income of \$5,000.....	150
	<hr/>
Medical expense deduction under sec. 213(a)(1)	1, 000

A's total section 213 deduction is \$1,250 (\$1,000 under paragraph (1), plus \$250 under paragraph (2)).

Limitation with respect to medicine and drugs

Section 106(b) of the bill amends section 213(b) of the code (relating to the limitation with respect to medicine and drugs).

Section 213(b) of the code provides as a general rule that in computing his medical expense deduction, the taxpayer shall take into account only the aggregate of the amounts paid for medicine and drugs in excess of 1 percent of adjusted gross income. However, the 1-percent limitation does not apply to amounts paid during the taxable year for medicines and drugs (1) for the care of the taxpayer and his spouse if either has attained age 65 before the close of the taxable year, or (2) for the care of the mother or father of the taxpayer or his spouse if such parent is a dependent (as defined in sec. 152 of the code) of the taxpayer or his spouse and has attained age 65 before the close of the taxable year. Section 106(b) of the bill repeals the exceptions to the 1-percent limitation. Thus, under the bill, the 1-percent floor applies to all expenses for drugs and medicines without exception.

Definition of medical care

Section 106(c) of the bill strikes out paragraph (1) of section 213(e) of the code (which defines medical care to mean amounts paid (A) for the diagnosis, cure, mitigation, treatment, or prevention of disease or for the purpose of affecting any structure or function of the body (including amounts paid for accident or health insurance), or (B) for transportation primarily for and essential to medical care described in (A)) and replaces it with new paragraphs (1), (2), and (3). The existing paragraph (2) is renumbered as paragraph (4). No substantive change is made in the definition of medical care except as it relates to amounts paid for insurance.

Under the new paragraph (1), subparagraphs (A) and (B) are the same as existing law except for the elimination of the phrase "including amounts paid for accident or health insurance". Under the new subparagraph (C), amounts paid for an insurance contract are included within the definition of medical care only to the extent that the premiums are attributable to insurance covering medical care (as defined in subparagraphs (A) and (B) of section 213(e)(1)). In determining whether a contract constitutes an "insurance" contract, it is irrelevant whether the benefits are payable in cash or services. Under the new paragraph (1)(C), premiums paid under part B of title XVIII of the Social Security Act (relating to supplementary health insurance for the aged) are amounts paid for insurance. Taxes paid under section 1401 (relating to tax on self-employment income) or under section 3101 (relating to tax on income of employees) of the Internal Revenue Code do not constitute amounts paid for insurance.

If amounts are payable under an insurance contract for other than medical care (such as an indemnity for loss of income or for loss of life, limb, or sight) then, under the new paragraph (2), no amount paid for such contract is to be treated as medical care unless (1) the contract specifies what part of the premium is attributable to insurance for medical care, and (2) the part of the premium specified in the contract as being so attributable is a reasonable amount in relation to the total premium under the contract. Moreover, the amount to

be treated as expenses for medical care in such a case is not to exceed the amount so specified in the contract.

Certain prepaid insurance

Under the new paragraph (3) added to section 213(e) of the code, subject to the limitations of the new paragraph (2), premiums paid during a taxable year by a taxpayer before he attains the age of 65 for insurance covering medical care for the taxpayer, his spouse, or a dependent after the taxpayer attains the age of 65 are to be treated as expenses paid during the taxable year for insurance which constitutes medical care if premiums for such insurance are payable (on a level payment basis) under the contract—

- (1) for a period of 10 years or more, or
- (2) until the year in which the taxpayer attains age 65 (but in no case for a period of less than 5 years).

Maximum limitation in certain cases

Section 106(d) of the bill amends section 213(g) of the code (which provides for an increased maximum limitation on the medical expense deduction allowable to a taxpayer who has attained the age of 65 and is disabled or whose spouse has attained the age of 65 and is disabled) to eliminate the requirement of attaining age 65 so that the increased maximum limitation is applicable in any case where either the taxpayer or his spouse is disabled.

Effective date

Section 106(e) of the bill provides that the amendments made by section 106 shall apply to taxable years beginning after December 31, 1966.

SECTION 107. RECEIPTS FOR EMPLOYEES MUST SHOW TAXES SEPARATELY

Section 107 of the bill amends section 6051(c) of the Internal Revenue Code of 1954 to provide that the statement (form W-2) furnished to an employee pursuant to section 6051 of the code must show the proportion of the amounts withheld as tax under section 3101 which is for financing the cost of hospital insurance benefits under part A of title XVIII of the Social Security Act.

SECTION 108. TECHNICAL AND ADMINISTRATIVE AMENDMENTS RELATING TO TRUST FUNDS

Paragraph (1) of section 108(a) of the bill amends section 201(a)(3) of the Social Security Act to exclude the taxes imposed on employers and employees for hospital insurance under sections 3101(b) and 3111(b) of the Internal Revenue Code of 1954, as amended by section 321 of the bill, from the employer and employee taxes appropriated to the Federal Old-Age and Survivors Insurance Trust Fund.

Paragraph (2) of section 108(a) of the bill amends section 201(a)(4) of the act to exclude the taxes imposed on the self-employed for hospital insurance under section 1401(b) of the Code, as amended by section 321 of the bill, from the self-employment taxes appropriated to the Federal Old-Age and Survivors Insurance Trust Fund.

Paragraph (3) of section 108(a) of the bill amends section 201(g)(1) of the act, relating to payments from the trust funds to the Treasury

as reimbursement for administrative costs of title II of the act and chapters 2 and 21 of the Internal Revenue Code of 1954.

The new subparagraph (A) of section 201(g)(1) provides for payment from any or all of the Trust Funds (which include for this purpose the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, the Federal Hospital Insurance Trust Fund, and the Federal Supplementary Health Insurance Benefits Trust Fund) of the costs to the Department of Health, Education, and Welfare of administering titles II and XVIII of the act and for adjustments during, and after the close of, each fiscal year among the Trust Funds so that each fund bears its proportionate share of the costs of administering titles II and XVIII.

The new subparagraph (B) of section 201(g)(1) provides for payments from the Trust Funds to the Treasury to meet the estimated quarterly costs to the Treasury of the administration of titles II and XVIII of the act and of chapters 2 and 21 of the Internal Revenue Code of 1954.

Paragraph (4) of section 108(a) of the bill amends section 201(g)(2) of the act to specify that in estimating the amount of employee taxes subject to refund the Managing Trustee of the old-age, survivors, and disability insurance trust funds shall consider only the taxes imposed for the support of the old-age and survivors insurance and disability insurance programs. (This provision conforms with the provisions of the new section 1817(f) of the act for estimating amounts of employee taxes imposed for the hospital insurance program that are subject to refund because of overpayment.)

Paragraph (5) of section 108(a) of the bill amends section 201(h) of the act to specify that payments made under the new section 226 of the act (relating to entitlement to hospital insurance benefits) are not to be made from the Federal Old-Age and Survivors Insurance Trust Fund.

Section 108(b) of the bill amends section 218(h)(1) of the act (relating to the depositing in the trust funds of amounts received by the Secretary of the Treasury under agreements for coverage of State and local government employees) to provide for proportionate deposits in the Federal Hospital Insurance Trust Fund as well as in the existing trust funds.

Section 108(c) of the bill amends section 1106(b) of the act so that the two new insurance trust funds established by the bill, like the old-age, survivors, and disability insurance trust funds, may be reimbursed for costs of furnishing information (disclosure of which is authorized by regulations) or services to individuals or organizations.

SECTION 109. ADVISORY COUNCIL ON SOCIAL SECURITY

Section 109 of the bill replaces the existing provision for the appointment of Advisory Councils on Social Security Financing with a new provision for the appointment of Advisory Councils on Social Security.

Section 109(a) of the bill adds a new section 706 to title VII of the Social Security Act to provide for the appointment by the Secretary of Health, Education, and Welfare of an Advisory Council on Social Security in 1968 and every fifth year thereafter to review the status of the 4 named trust funds in relation to the long-term commitments of the old-age, survivors, and disability insurance program,

the hospital insurance program, and the supplementary health insurance benefits program and to review also the scope of coverage and the adequacy of benefits under, and all other aspects of, these programs, including their impact on the public assistance programs. Each Council is to consist of the Commissioner of Social Security, as chairman, and 12 members who will, to the extent possible, represent organizations of employers and employees in equal numbers, and represent self-employed persons and the public. The Councils are authorized to engage technical assistance, including actuarial services, and the Secretary is required to make available to the Council secretarial, clerical, and other assistance and such pertinent data prepared by the Department of Health, Education, and Welfare as the Council might require. While serving on business of the Council, the members of the Council will receive compensation at rates fixed by the Secretary but not exceeding \$100 per day, and, while serving away from their homes or regular places of business, they will be allowed travel expenses, including per diem in lieu of subsistence. Each Council is to make reports of its findings and recommendations to the Secretary of Health, Education, and Welfare for transmission to the Congress and to the Board of Trustees of each of the 4 trust funds not later than January 1 of the second year after the year in which it was appointed, and then will cease to exist. Separate reports are required with respect to (1) the old-age, survivors, and disability insurance program, (2) the hospital insurance program, and (3) the supplementary health insurance benefits program.

Section 109(b) of the bill repeals section 116(e) of the Social Security Amendments of 1956 (which is the section presently providing for the appointment by the Secretary in 1966 and every fifth year thereafter of an Advisory Council on Social Security Financing with functions limited to review of the financing aspects of the program).

SECTION 110. MEANING OF TERM "SECRETARY"

Section 110 of the bill provides that, as used in the bill and in the provisions of the Social Security Act amended thereby, the term "Secretary" (unless the context otherwise requires) means the Secretary of Health, Education, and Welfare.

PART 2—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

SECTION 121. ESTABLISHMENT OF PROGRAMS

Section 121(a) of the bill adds a new title XIX, providing grants to States for medical assistance programs, to the Social Security Act.

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

SECTION 1901. APPROPRIATION

Section 1901 authorizes the appropriation for each fiscal year of a sum sufficient to carry out the purposes of title XIX, in order to enable each State (as far as practicable under the conditions in such State) to furnish medical assistance on behalf of aged, blind, or

permanently and totally disabled individuals and families with dependent children, whose income and resources are insufficient to meet the costs of necessary medical services, and rehabilitation and other services to help such individuals and families attain or retain capability for independence or self-care. The sums made available under this section are to be used for making payments to States which have submitted and had approved State plans for medical assistance. (Sec. 1903(a) provides that such payments are to be made beginning with the quarter commencing January 1, 1966.)

SECTION 1902. STATE PLANS FOR MEDICAL ASSISTANCE

Section 1902(a) sets forth the requirements with which a State plan for medical assistance must comply in order to be approved by the Secretary of Health, Education, and Welfare and thereby qualify the State for payments under title XIX. To be approved, such a State plan must—

- (1) provide that it will be in effect in all political subdivisions of the State and, if the plan is administered by the subdivisions, that it be mandatory upon them;

- (2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which Federal financial participation under section 1903 is authorized and, effective July 1, 1970, provide for State financial participation equal to all of such non-Federal share;

- (3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or not acted upon with reasonable promptness;

- (4) provide methods of administration of the plan as found necessary by the Secretary for its proper and efficient operation; these would include (A) methods relating to the establishment and maintenance of personnel standards on a merit basis, with the Secretary being precluded from exercising any authority in connection with the selection, tenure, or compensation of any individual employed in accordance with these methods, and (B) provision for utilization of professional medical personnel in the administration of the plan, and in supervision of such administration where the plan is administered locally;

- (5) provide that the State agency administering or supervising the State old-age assistance plan approved under title I, or the State plan for aid to the aged, blind, or disabled approved under title XVI (insofar as it relates to the aged), will administer the plan for medical assistance or supervise its administration; and that any local agency administering the State's plan approved under title I or under title XVI (insofar as it relates to the aged) in a political subdivision will administer the plan for medical assistance in that subdivision;

- (6) provide that the State agency will make reports as required by the Secretary, and will comply with provisions found necessary by the Secretary to assure their correctness and verification;

- (7) provide safeguards which restrict the use or disclosure of information concerning applicants or recipients to purposes directly connected with the plan's administration;

(8) provide for affording all individuals who wish to do so an opportunity to apply for medical assistance under the plan and for furnishing such assistance with reasonable promptness to all applicants who are eligible for assistance under the plan;

(9) provide for a State authority or authorities with responsibility to establish and maintain standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services;

(10) provide for making medical assistance available to all individuals receiving old-age assistance, aid to families with dependent children, aid to the blind, aid to the permanently and totally disabled, and aid to the aged, blind, or disabled under the State's plans approved under titles I, IV, X, XIV, and XVI of the act; and—

(A) provide that the medical assistance made available to individuals receiving aid or assistance under any one of such plans—

(i) will not be less in amount, duration, or scope than the medical assistance made available to individuals receiving aid or assistance under any other such plan; and

(ii) will not be less in amount, duration, or scope than medical assistance made available to individuals not receiving aid or assistance under any such plan; and

(B) if the plan under title XIX includes medical assistance for any group of individuals who are not recipients under any such plan and do not meet the State's income and resource requirements under the one of such plans which, as determined in accordance with standards prescribed by the Secretary, is appropriate, provide—

(i) for making medical assistance available to all individuals who if needy would be eligible for aid or assistance under any such plan and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the cost of necessary medical care and services, and

(ii) that the medical assistance made available to all individuals who are not recipients under any such State plan will be equal in amount, duration, and scope;

(11) provide for entering into cooperative arrangements with the State agencies responsible for health and vocational rehabilitation services looking toward maximum utilization of these services in providing medical assistance under the plan;

(12) provide that in determining blindness an examination will be made either by a physician skilled in diseases of the eye or by an optometrist, as the individual may select;

(13) provide for inclusion of some institutional and some non-institutional care and services and, as of July 1, 1967, for the inclusion of at least (1) inpatient hospital services, (2) outpatient hospital services, (3) other laboratory and X-ray services, (4) skilled nursing home services, and (5) physicians' services (as listed in section 1905(a)); and for the payment of the reasonable cost (as determined in accordance with standards approved by the Secretary and included in the plan) of inpatient hospital services provided under the plan;

(14) provide that—

(A) no deduction, cost sharing, or similar charge will be imposed on any individual with respect to inpatient hospital services furnished him under the plan, and

(B) any deduction, cost sharing, or similar charge imposed as to any other care or services furnished him thereunder, and any enrollment fee, premium, or similar charge imposed under the plan, will be reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to the recipient's income or to his income and resources;

(15) in the case of eligible individuals 65 years of age or older covered by either or both of the insurance programs (hospital insurance benefits for the aged, and supplementary health insurance benefits for the aged) established by the bill, provide—

(A) for meeting the full cost of any deductible imposed with respect to any such individual under such hospital insurance benefits program; and

(B) where, under the plan, all of a deductible, cost sharing, or similar charge imposed with respect to any such individual under such supplementary health insurance benefits program is not met, the portion which is met shall be determined on a basis reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to such individual's income or to his income and resources;

(16) include, to the extent required by regulations of the Secretary, provisions (conforming to such regulations) regarding the furnishing of medical assistance to eligible residents who are absent from the State;

(17) include reasonable standards, comparable for all groups, for determining eligibility for and the extent of medical assistance under the plan, which standards—

(A) are consistent with the objectives of title XIX,

(B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who if he met the State's need requirements would be eligible for aid or assistance in the form of money payments under the State's plan approved under title I, IV, X, XIV, or XVI) as would not be disregarded (or set aside for future needs) in determining his eligibility for and the amount of aid or assistance under such plan,

(C) provide for reasonable evaluation of any such income or resources, and

(D) do not take into account the financial responsibility of any individual for any applicant or recipient unless such applicant or recipient is the individual's spouse or is his child who is under age 21 or, if the child is age 21 or over, is blind or permanently and totally disabled; and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the pre-

insurance premiums or otherwise) incurred for medical care or any other type of remedial care recognized under State law;

(18) provide that property liens will not be imposed, on account of medical assistance provided under the plan, during a recipient's lifetime (except pursuant to a judgment of a court on account of benefits incorrectly paid), and preclude adjustments or recovery of medical assistance correctly paid except from the estate of a recipient who was at least age 65 when he received such assistance, and then only after the death of his surviving spouse and at a time when he has no surviving child who is under 21, blind, or permanently and totally disabled;

(19) provide safeguards necessary to assure that eligibility for care and services under the plan will be determined and such care and services will be provided in a manner consistent with simplicity of administration and the best interests of the recipients;

(20) if the State plan includes medical assistance in behalf of individuals 65 years or older who are patients in institutions for tuberculosis or mental diseases—

(A) provide for agreements or other arrangements, with State authorities concerned with mental diseases or tuberculosis (as the case may be) and, where appropriate, with such institutions, necessary for carrying out the State plan. These will include arrangements for joint planning and for development of alternate methods of care, for assuring immediate readmittance to institutions where needed for individuals under alternate plans of care, for providing for access to patients and facilities, and for submitting information and reports;

(B) provide for an individual plan for each such patient to assure that the institutional care provided is in his best interests, including assurances of initial and periodic review of his medical and other needs, of his receiving appropriate medical treatment within the institution, and of periodic determination of his need for continued institutional care;

(C) provide for the development of alternate plans of care with maximum utilization of available resources for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance; for services to help such recipients and patients attain or retain capability for self-care or other services to prevent or reduce dependency which are appropriate; and for methods of administration necessary to assure that the State plan with respect to these recipients and patients will be effectively carried out; and

(D) provide methods of determining the reasonable cost of institutional care for such patients; and

(21) if the State plan includes medical assistance in behalf of individuals 65 years or older who are patients in public institutions for mental diseases, show that the State is making satisfactory progress toward a comprehensive mental health program.

Section 1902(a) also provides that, notwithstanding the requirement in paragraph (5) above, any State which (on January 1, 1965, and on the date it submits its plan under title XIX) administers or supervises

its program for the blind under title X (or under title XVI, insofar as it relates to the blind) through a State agency other than the State agency that administers or supervises its title I plan (or title XVI plan, insofar as it relates to the aged) will be permitted, upon coming under title XIX, to retain such separate blind program agency to administer or supervise (as a separate State plan, except for purposes of paragraph (10) above) the portion of the approved plan for medical assistance under title XIX which relates to blind individuals.

Section 1902(b) requires the Secretary of Health, Education, and Welfare to approve any plan which fulfills the conditions specified in section 1902(a), except that he is not to approve any plan which imposes as a condition of eligibility for medical assistance under the plan—

- (1) an age requirement of more than 65 years; or
- (2) effective July 1, 1967, any age requirement which excludes any individual who has not attained the age of 21 and who meets the definition of a dependent child under title IV of the act disregarding the provisions of section 406(a)(2); or
- (3) any residence requirement which excludes any individual residing in the State; or
- (4) any citizenship requirement which excludes any citizen of the United States.

Section 1902(c) requires the Secretary, notwithstanding the fact that a State plan is otherwise approvable, not to approve such plan if he determines that its approval and operation will result in a reduction in aid or assistance (other than so much as is provided under the approved title XIX plan) provided for eligible individuals under the State's plan approved under title I, IV, X, XIV, or XVI.

SECTION 1903. PAYMENT TO STATES

Section 1903(a) provides for making Federal payments to States with respect to expenditures for programs of medical assistance under approved plans. Except as otherwise provided in section 1903 and in section 1117 (as added to title XI of the Social Security Act by sec. 405 of the bill), the Secretary will pay each State with an approved plan for medical assistance, for each quarter, beginning with the quarter commencing January 1, 1966—

- (1) an amount equal to the Federal medical assistance percentage (as defined in sec. 1905(b)) of the total medical assistance expenditures during the quarter, including in such expenditures premiums under part B of title XVIII (relating to supplementary health insurance benefits for the aged) for recipients of money payments under title I, IV, X, XIV, or XVI, and other insurance premiums for medical or remedial care or the cost of such care; plus
- (2) an amount equal to 75 percent of the amounts expended during the quarter for administrative costs attributable to compensation of skilled professional medical personnel and directly-supporting staff of the State agency or local agency administering the plan; plus
- (3) one-half of the remaining administrative expenses.

Section 1903(b) provides that, notwithstanding the provisions of section 1903(a), the amount of the Federal payment for any quarter

attributable to expenditures with respect to individuals 65 years of age or older who are patients in institutions for tuberculosis or mental diseases is to be paid only to the extent that total expenditures from Federal, State, and local funds for mental health services under State and local public health and public welfare programs for the quarter are shown to the satisfaction of the Secretary to exceed the average of the total expenditures for these services for each quarter of the fiscal year ending June 30, 1965. The expenditures for these services for each quarter in the fiscal year ending June 30, 1965, are to be determined on the basis of the latest data, satisfactory to the Secretary, available to him at the time of the first determination under section 1903(b); and expenditures for any quarter beginning after December 31, 1965, are to be determined on the basis of the latest data, satisfactory to the Secretary, available to him at the time of the determination for such State for such quarter. For the purposes of section 1903(b), such determinations will be conclusive.

Section 1903(c) provides that if the Secretary finds, on the basis of satisfactory information submitted by a State, that its Federal medical assistance percentage applicable to any quarter during the period January 1, 1966, through June 30, 1969, is less than 105 percent of the Federal share of the State's medical expenditures during the fiscal year ending June 30, 1965, then its Federal medical assistance percentage will be 105 percent of such Federal share instead of the percentage determined under section 1905(b). Such adjusted percentage will be applicable for such quarter and each subsequent quarter in such period prior to the first quarter as to which such finding is not applicable.

For the above purposes, such Federal share means the percentage which the excess of—

(A) the total of the amounts of the Federal shares (determined under the applicable formulas of the public assistance titles of the act) of the State's expenditures for aid or assistance in any form during fiscal year 1965 under its plans approved under titles I, IV, X, XIV, and XVI over

(B) the total of the Federal shares determined under such formulas with respect to its expenditures of aid or assistance during such year, excluding aid or assistance in the form of medical or remedial care,

is of the total of aid or assistance expenditures in the form of medical or remedial care under such plans during such year.

Section 1903(d) provides procedures for paying to a State the amounts to which it is entitled under the preceding provisions of section 1903. These are, with appropriate modifications, similar to those under the existing public assistance titles of the act.

Section 1903(e) provides that payments under the preceding provisions of section 1903 are not to be made unless the State makes a satisfactory showing that it is making efforts toward broadening the scope of the care and services available under its plan and toward liberalizing the eligibility requirements for medical assistance, looking toward providing, by July 1, 1975, comprehensive care and services to substantially all individuals who meet the plan's eligibility requirements with respect to income and resources, including services to help such individuals to attain independence or self-care.

SECTION 1904. OPERATION OF STATE PLANS

Section 1904 provides for withholding of Federal payments to a State if the Secretary finds, after reasonable notice and opportunity for hearing to the State agency having responsibility for the plan, that the approved plan has been so changed that it no longer complies with the provisions of section 1902 or that in the administration of the plan there is failure to comply substantially with any such provision. Until the Secretary is satisfied that there is no longer any failure to comply, he will make no further payments to the State or in his discretion will limit payments to categories under or parts of the plan not affected by such failure.

SECTION 1905. DEFINITIONS

Section 1905(a) defines the term "medical assistance" to mean payment of part or all of the cost of the following care and services (if provided in or after the third month before the month the recipient makes application) for individuals who are under the age of 21 and who except for section 406(a)(2) are (or would, if needy, be) dependent children as defined under title IV, or who are relatives specified in section 406(b)(1) with whom such children are living, or who are 65 years of age or older, are blind, or are 18 years of age or older and permanently and totally disabled, but whose income and resources are insufficient to meet all of such cost—

- (1) inpatient hospital services;
- (2) outpatient hospital services;
- (3) other laboratory and X-ray services;
- (4) skilled nursing home services;
- (5) physicians' services, whether furnished in the office, the patient's home, a hospital, a skilled nursing home, or elsewhere;
- (6) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;
- (7) home health care services;
- (8) private duty nursing services;
- (9) clinic services;
- (10) dental services;
- (11) physical therapy and related services;
- (12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;
- (13) other diagnostic, screening, preventive, and rehabilitative services; and

(14) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary; but the term does not include—

(A) payments with respect to care or services for an individual who is an inmate of a public institution (except as a patient in a medical institution); or

(B) payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases.

Section 1905(b) defines the term "Federal medical assistance percentage". Such percentage for a State is 100 per centum minus the percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the 50 States and the District of Columbia. Such percentage is in no case less than 50 per centum or more than 83 per centum, except that for Puerto Rico, the Virgin Islands, and Guam it is set at 55 per centum. Determination and promulgation by the Secretary of the Federal medical assistance percentage will be in accordance with the provisions of section 1101(a)(8)(B) of the act, except that such promulgation will be made as soon as possible after enactment of the bill and it will be conclusive for each of the 6 quarters in the period January 1, 1966, through June 30, 1967.

SECTION 121. ESTABLISHMENT OF PROGRAMS—(Con.)

Section 121(b) of the bill provides that no payment may be made to any State under title I, IV, X, XIV, or XVI of the Social Security Act for aid or assistance in the form of medical or any other type of remedial care for any period for which such State receives payments under title XIX (as added to such act by sec. 121(a) of the bill), or for any period after June 30, 1967.

Paragraph (1) of section 121(c) of the bill (effective January 1, 1966) amends section 1101(a)(1) of the act to make a necessary conforming change.

Paragraph (2) of section 121(c) of the bill amends section 1109 of the act to provide that any amount which is disregarded (or set aside for future needs) in determining eligibility for and amount of the aid or assistance for an individual under a State plan approved under title I, IV, X, XIV, XVI, or XIX of the act is not to be taken into consideration in determining the eligibility for or amount of medical assistance for any other individual under a State plan approved under such title XIX.

Paragraph (3) of section 121(c) of the bill (effective January 1, 1966) amends section 1115 of the act to make necessary conforming changes.

SECTION 122. PAYMENT BY STATES OF PREMIUMS FOR SUPPLEMENTARY HEALTH INSURANCE

Section 122 of the bill amends sections 3(a), 403(a), 1003(a), 1403(a), and 1603(a) of the Social Security Act to authorize Federal financial participation in expenditures by a State under its approved plans under the respective public assistance titles of such act for premiums paid for supplementary health insurance benefits for the aged (the insurance program under part B of title XVIII of the Social Security Act, as added by the bill) for individuals who receive money payments under any such title.

TITLE II—OTHER AMENDMENTS RELATING TO HEALTH CARE

PART 1—MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S SERVICES

SECTION 201. INCREASE IN MATERNAL AND CHILD HEALTH SERVICES

Section 201(a) of the bill amends section 501 of the Social Security Act to increase the authorization of appropriations for grants to the States for maternal and child health services under part 1 of title V of such Act to \$45 million for the fiscal year ending June 30, 1966; \$50 million for the fiscal year ending June 30, 1967; \$55 million each for the fiscal years ending June 30, 1968 and 1969; and \$60 million for the fiscal year ending June 30, 1970, and for each fiscal year thereafter. Under existing law the authorized appropriation is \$40 million each for the fiscal years ending June 30, 1966 and 1967, \$45 million each for the fiscal years ending June 30, 1968 and 1969, and \$50 million for the fiscal year ending June 30, 1970, and for each year thereafter.

Section 201(b) of the bill amends section 504 of the Act by adding a new subsection (d) which makes payments to States after June 30, 1966, contingent upon a satisfactory showing that the State is extending the provision of maternal and child health services in the State with a view to making such services available to children in all parts of the State by July 1, 1975.

SECTION 202. INCREASE IN CRIPPLED CHILDREN'S SERVICES

Section 202(a) of the bill amends section 511 of the Social Security Act to increase the authorization of appropriations for grants to the States for crippled children's services under part 2 of title V of such Act to \$45 million for the fiscal year ending June 30, 1966; \$50 million for the fiscal year ending June 30, 1967; \$55 million each for the fiscal years ending June 30, 1968 and 1969; and \$60 million for the fiscal year ending June 30, 1970, and for each fiscal year thereafter. Under existing law the authorized appropriation is \$40 million each for the fiscal years ending June 30, 1966 and 1967, \$45 million for the fiscal years ending June 30, 1968 and 1969, and \$50 million for the fiscal year ending June 30, 1970, and for each fiscal year thereafter.

Section 202(b) of the bill amends section 514 of the Act by adding a new subsection (d) which makes payments to States after June 30, 1966, contingent upon a satisfactory showing that the State is extending the provision of crippled children's services in the State with a view to making such services available to children in all parts of the State by July 1, 1975.

SECTION 203. TRAINING OF PROFESSIONAL PERSONNEL FOR THE CARE OF CRIPPLED CHILDREN

Section 203 of the bill amends part 2 of title V of the Social Security Act by adding a new section 516 which authorizes grants to public or other nonprofit institutions of higher learning for training professional personnel for health and related care of crippled children, particularly mentally retarded children and children with multiple handicaps. Authorizations for appropriations are \$5 million for the fiscal year ending June 30, 1967, \$10 million for the fiscal year ending June 30, 1968, and \$17.5 million for each fiscal year thereafter.

SECTION 204. PAYMENT FOR INPATIENT HOSPITAL SERVICES

Section 204(a) of the bill amends section 503(a) of the Social Security Act to require a State plan for maternal and child health services to provide, effective July 1, 1967, for payment of the reasonable cost (as determined in accordance with standards approved by the Secretary and included in the plan) of inpatient hospital services provided under the plan.

Section 204(b) of the bill amends section 513(a) of the Act to require a State plan for services for crippled children to provide, effective July 1, 1967, for payment of the reasonable cost (as determined in accordance with standards approved by the Secretary and included in the plan) of inpatient hospital services provided under the plan.

SECTION 205. SPECIAL PROJECT GRANTS FOR HEALTH OF SCHOOL AND PRESCHOOL CHILDREN

Section 205 of the bill amends part 4 of title V of the Social Security Act by inserting a new section to provide special project grants to promote the health of school and preschool children. In conforming changes the heading of part 4 is revised accordingly and section 532 is redesignated section 533.

The new section 532(a) authorizes appropriations of \$15 million for the fiscal year ending June 30, 1966, \$35 million for the fiscal year ending June 30, 1967, \$40 million for the fiscal year ending June 30, 1968, \$45 million for the fiscal year ending June 30, 1969, and \$50 million for the fiscal year ending June 30, 1970, for special project grants in order to promote the health of children and youth of school and preschool age, particularly in areas with concentrations of low income families. Section 532(b) authorizes the Secretary to make grants to a State health agency and (with the consent of such agency) to the health agency of any political subdivision of the State, to the State agency administering or supervising the administration of the crippled children's program under part 2q title V of the Social Security Act, to any school of medicine (with appropriate participation by a school of dentistry), and to any teaching hospital affiliated with such a school, to pay not to exceed 75 percent of the cost of projects of a comprehensive nature for health care and services for children and youth of school age or for preschool children (to help them prepare to start school). Projects for children and youth of school

age must include such screening, diagnosis, preventive services, treatment, correction of defects, and aftercare, both medical and dental, as may be provided for in regulations of the Secretary. Treatment, correction of defects, and aftercare are to be available under the projects only to children who would not otherwise receive them because they are from low income families or for other reasons beyond their control. Projects must provide for coordination of the health care and services provided under them with, and for utilization of, other State or local health, welfare, and education programs for children, and for payment of the reasonable cost of inpatient hospital services.

The new section 532(c) provides for payment of the grants under section 532 in advance or by way of reimbursement, in such installments and on such conditions as the Secretary determines.

SECTION 206. EVALUATION AND REPORT

Section 206 of the bill requires the Secretary to submit to the President for transmission to the Congress before July 1, 1969, a full report of the administration of section 532 of the Social Security Act (special project grants for health of school and preschool children) together with an evaluation of the program and recommendations as to continuation of and modifications in the program.

PART 2. IMPLEMENTATION OF MENTAL RETARDATION PLANNING

SECTION 211. AUTHORIZATION OF APPROPRIATIONS

Section 211(a) of the bill amends section 1701 of the Social Security Act to authorize appropriations for assisting States in initiating the implementation and carrying out of planning and other steps to combat mental retardation. The amounts authorized to be appropriated are \$2,750,000 for the fiscal year ending June 30, 1966, and \$2,750,000 for the fiscal year ending June 30, 1967.

Section 211(b) of the bill amends section 1702 of the act to provide that the sums appropriated pursuant to section 1701 for the fiscal year ending June 30, 1966, are to be available for grants during that fiscal year and the 2 immediately succeeding fiscal years, and that the sums appropriated for the fiscal year ending June 30, 1967, are to be available for such grants during that fiscal year and the immediately succeeding fiscal year.

PART 3—PUBLIC ASSISTANCE AMENDMENTS RELATING TO HEALTH CARE

SECTION 221. REMOVAL OF LIMITATIONS ON FEDERAL PARTICIPATION IN ASSISTANCE TO AGED INDIVIDU- ALS WITH TUBERCULOSIS OR MENTAL DISEASE

Paragraphs (1) and (2) of section 221(a) of the bill, and paragraphs (1) and (2) of section 221(d), amend the definitions of the terms "old-age assistance", "aid to the aged, blind, or disabled" (insofar

as it relates to the aged), and "medical assistance for the aged", as those terms appear in titles I and XVI of the Social Security Act. These amendments remove the limitations on Federal participation in aid or assistance to aged individuals who are patients in institutions for tuberculosis or mental diseases or who are patients in medical institutions as a result of a diagnosis of tuberculosis or psychosis.

Section 221 (b) and (c) of the bill, and paragraph (1) of section 221(d), amend the definitions of the terms "aid to the blind", "aid to the permanently and totally disabled", and "aid to the aged, blind, or disabled" (insofar as it relates to the blind or disabled), as those terms appear in titles X, XIV and XVI, respectively, of the Social Security Act so as to remove the existing limitations in those titles on Federal sharing in aid to individuals who are patients in medical institutions as a result of a diagnosis of tuberculosis or psychosis. Federal financial participation would remain unavailable with respect to payments to or care in behalf of blind or disabled individuals who are patients in an institution for tuberculosis or mental diseases under such titles X and XIV, and under such title XVI in the case of individuals under age 65.

Paragraph (3) of section 221(a) of the bill, and paragraph (3) of section 221(d), amend sections 2(a) and 1602(a), respectively, of the Social Security Act to add new plan requirements for a State which elects to include assistance in its State plan under title I (or aid or assistance in its State plan under title XVI, insofar as such aid relates to the aged) to or in behalf of individuals who are patients in tuberculosis or mental institutions. Such plan requirements are the same as those set forth in section 1902(a) (20) and (21) of title XIX as added to the Social Security Act by section 121(a) of the bill.

Paragraph (4) of section 221(a) of the bill, and paragraph (4) of section 221(d), add provisions to sections 3 and 1603, respectively, of the Social Security Act comparable to the provision set forth in section 1903(b) of title XIX (as added by section 121(a) of the bill). These provisions make the Federal share in State expenditures with respect to aged patients in institutions for tuberculosis or mental diseases contingent upon a comparable increase in total expenditures in the State for mental health services.

Section 221(e) of the bill provides that the amendments made by the preceding provisions of section 221 will apply to expenditures made after December 31, 1965, under a State plan approved under title I, X, XIV, or XVI of the Social Security Act.

SECTION 222. AMENDMENT TO DEFINITION OF MEDICAL ASSISTANCE FOR THE AGED

Sections 222(a) and 222(b) of the bill amend sections 6(b) and 1605(b), respectively, of the Social Security Act, to permit Federal sharing in State expenditures for medical assistance for the aged in the case of individuals who also received old-age assistance or aid to the aged, blind, or disabled in the month of their admittance to or discharge from a medical institution.

Section 222(c) of the bill provides that these amendments will apply to expenditures under a State plan approved under title I or XVI of the act with respect to care and services provided under such plan after June 1965.

TITLE III—SOCIAL SECURITY AMENDMENTS

Section 300 of the bill provides that title III of the bill may be cited as the "Old-Age, Survivors, and Disability Insurance Amendments of 1965".

SECTION 301. INCREASE IN OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

Section 301 of the bill provides for a revised benefit table to effectuate a 7-percent benefit increase and new maximum benefit amounts.

Primary insurance amount

Section 301(a) of the bill amends section 215 of the Social Security Act to substitute for the present benefit table a new table. The new table effectuates the increase for people who were on the benefit rolls in any month after December 1964 and provides benefit amounts higher than those under present law for people who come on the benefit rolls in and after the month in which the bill is enacted. The new primary insurance amounts, shown in column IV of the table, represent an increase of 7 percent in the primary insurance amounts, with a minimum increase of \$4, over the primary insurance amounts provided in present law, for average monthly wages up to and including \$400 a month. (The primary insurance amount is the amount payable to a worker who retires at or after age 65 or to a disabled worker, and it is also the amount from which all other benefits are determined.)

An approximation of the benefits shown in the new benefit table can be arrived at by taking 62.97 percent of the first \$110 of the average monthly wage, plus 22.9 percent of the next \$290, plus 21.4 percent of the next \$66. Benefits in the present table approximate 58.85 percent of the first \$110 of average wage plus 21.4 percent of the next \$290.

The primary insurance amounts provided by the revised table range from a minimum of \$44 for people whose average monthly wage is \$67 or less to a maximum of \$149.90 for people who have the average monthly wage of \$466 that will become possible in the future with the \$5,600 contribution and benefit base which the bill (in sec. 320) provides. The primary insurance amounts of retired workers who are now on the benefit rolls is raised from \$40 to \$44 at the minimum and from \$127 to \$135.90 at the maximum.

Under the revised benefit table, the total monthly amount of benefits payable to a family on the basis of a single earnings record will be determined on the basis of a new formula. The maximum family benefit in present law (shown in column V of the benefit table) is the smaller of 80 percent of the average monthly wage or \$254—twice the maximum primary insurance amount of \$127—but it does not operate to reduce the family benefits to less than $1\frac{1}{2}$ times the primary insurance amount. The \$254 amount applies over a rather wide range of average monthly wage levels, so that the maximum family benefit is not wage-related at average monthly wage levels above \$317. The formula used to determine the new maximum family benefit amounts (these amounts are shown in column V of the benefit table in the bill) is 80 percent of the average monthly wage up to the point at which the average monthly wage amount is two-thirds of the maximum possible average

monthly wage specified in the law, plus 40 percent of the remainder of the average monthly wage. This formula produces, at the maximum average monthly wage, a maximum family benefit of two-thirds of the average monthly wage. Specifically, with the \$5,600 contribution and benefit base, the 40-percent part of the formula would begin to operate above the \$314 average monthly wage level, which is about two-thirds of the maximum average monthly wage of \$466 (more precisely, it is the top of the average-monthly-wage bracket that includes the amount that is two-thirds of \$466). As under present law, the maximum will not operate to reduce family benefits below $1\frac{1}{2}$ times the primary insurance amount. (Because this new formula for determining the maximum family benefits would result in lower family benefits (\$253.20) than are provided under present law for average monthly wages in the range \$315 to \$319, the present \$254 maximum is retained for this range in the new table.)

Primary insurance amount under 1958 act, as modified

Section 301(b) of the bill amends section 215(c) of the act to provide that a person who became entitled to old-age or disability insurance benefits before the date of enactment of the bill, or who died before such date, will have his primary insurance amount, as determined under the provisions of present law and appearing in column II of the revised table, converted to the higher primary insurance amount appearing on the same line in column IV of the new table. Under present law, column II shows the primary amounts in effect prior to the Social Security Amendments of 1958 and column IV of the table shows the amounts to which the primary insurance amounts in column II were converted as a result of those amendments.

Maximum benefits for people already on the rolls

Section 301(c) of the bill amends section 203(a)(2) of the act to assure an increase in the family benefits for families who were on the benefit rolls after December 1964 and whose benefits were determined under the provisions of the law in effect prior to the enactment of the bill. In the absence of such a provision some families now on the benefit rolls could receive little or no increase in benefits, since their benefits are already at or near the maximum amount that would be payable to the family. The bill provides that the maximum family benefit for each month after December 1964 will be the larger of (1) the family maximum specified in column V of the new table or (2) the sum of all family members' benefits after each such benefit has been increased by 7 percent (and rounded to the next higher 10 cents if it is not already a multiple of 10 cents). The section also repeals section 203(a)(3) of the act, which is a special saving clause for the maximum family benefits of people who became disabled before 1959. This clause is no longer needed since families whose benefits were determined under this clause are now covered by paragraph (2) of section 203(a) as amended by the bill.

Effective date

Section 301(d) of the bill provides that the benefit increases provided for by subsections (a), (b), and (c) of section 301 will be effective for monthly benefits for months after December 1964 and for lump-sum death payments where death occurs in or after the month of enactment of the bill.

Special provision for conversion of a disability insurance benefit to an old-age insurance benefit

Section 301(e) of the bill is a special transitional provision which applies to an individual who was entitled to a disability insurance benefit for December 1964 and who became entitled to old-age insurance benefits in January 1965, to make certain that his primary insurance amount is increased. The general rule, provided in section 215(a)(4) of present law, that would apply in this situation is that an individual who was entitled to a disability insurance benefit for the month before he becomes entitled to an old-age insurance benefit will have as his primary insurance amount (and therefore his old-age insurance benefit) the amount in column IV of the table that is equal to his disability insurance benefit. In the situation outlined above, the individual's disability insurance benefit, since it was derived from a primary insurance amount determined under present law, does not have any direct connection with column IV of the table, which contains the new benefit amounts; and thus the general rule cannot be applied to this individual. Therefore, section 301(e) of the bill provides that his primary insurance amount is the amount in column IV of the table on the same line as that on which, in column II, appears his present primary insurance amount. (This primary insurance amount in col. II is equal to his disability insurance benefit under present law.)

Additional primary insurance amounts effective in January 1971

Section 301(f) of the bill revises and extends the benefit table effective with monthly benefits payable for January 1971. The benefit table is extended to take account of average monthly wages up to \$550, the maximum average monthly wage that will be possible under the \$6,600 annual contribution and benefit base that will be effective for years after 1970. Under the extended table, additional primary insurance amounts are provided up to a maximum of \$167.90, based on an average monthly wage of \$550.

The maximum family benefits were revised and extended on the basis of the same formula that was used in arriving at the maximum family benefits in the table provided in section 301(a). As a result, increased family maximum amounts are provided for average monthly wages of \$315 to \$466 (the maximum average monthly wage under the \$5,600 base), since with the increase in the base the point up to which the 80-percent part of the formula applies is raised from \$314 to \$370. Also, of course, higher maximum family benefits are provided for the average monthly wages above \$466 that will be possible under the \$6,600 base, up to a maximum of \$368 for an average monthly wage of \$550.

SECTION 302. COMPUTATION AND RECOMPUTATION OF BENEFITS

Section 302 of the bill provides for automatic recomputation of benefit amounts under title II of the Social Security Act to take account of earnings after entitlement to benefits, and makes technical changes in the provisions for computation of benefits to facilitate automatic recomputation.

Average monthly wage

Section 302(a)(1) of the bill amends subparagraph (C) of section 215(b)(2) of the act to exclude from an insured individual's computation base years (from which the years to be used in the benefit computation are chosen) the year in which he became entitled to benefits and to include in his computation base years (for purposes of survivors' benefits) the year in which he died. As a result of this change, an individual's computation base years are the calendar years occurring after 1950 (or after 1936, as provided in section 215(d)) and up to the year in which his first month of entitlement to a benefit occurs or the year after the year in which he dies.

Section 302(a)(2) amends section 215(b)(3) of the act to provide that the number of an individual's elapsed years (which determine the number of years to be used in the benefit computation) will be counted up to the year in which he reaches age 65 (age 62 for women) or dies whether or not he is fully insured in that year. Under present law, an individual's elapsed years are counted up to the year in which he is *both* fully insured and age 65 (62 for women). Since almost all insured individuals are now insured by the time they reach the required age, the deletion of the provision in present law results in a simplification of the computation provisions.

Section 302(a)(3) amends paragraphs (4) and (5) of section 215(b) of the act. Paragraph (4), as amended, makes the new provisions of section 215(b) applicable only in the case of an individual who dies or becomes entitled to benefits or to a benefit recomputation under section 215(f)(2), as amended by the bill, after December 1965. The requirement in present law that an individual have not less than six quarters of coverage after 1950 in order to have his average monthly wage determined entirely on his earnings after 1950 is omitted from the amended paragraph. Paragraph (5), as amended, preserves the present method of computing the average monthly wage for people who, after the bill is enacted and prior to 1966 (the effective date of automatic recomputation), become entitled to benefits or a recomputation of benefits.

Primary insurance benefit under 1939 act

Section 302(b) of the bill makes a minor conforming change and updates a reference in section 215(d) of the act, relating to computation of primary insurance benefits under the 1939 Social Security Act.

Certain wages and self-employment income not to be counted

Section 302(c) of the bill amends section 215(e) of the act by striking out paragraph (3), which provides for a recomputation, for self-employed people who operate on a fiscal-year basis, to include earnings in the year of entitlement that were not available for inclusion in the original computation. This provision will not be needed, since these earnings will be taken into account under the automatic recomputation provisions which will be provided under section 215(f) as amended by the bill.

Recomputation of benefits

Section 302(d)(1) of the bill amends section 215(f)(2) of the act by providing for annual automatic recomputation of benefits, beginning in 1966.

The recomputation will take into account any earnings the person had in or after the year in which he became entitled to benefits (under

present law, a recomputation to include earnings in a year after entitlement requires an application and is not available unless the person had earnings of more than \$1,200 for the year). The bill would also delete the requirements in present law that the person have six quarters of coverage after 1950 in order to qualify for the recomputation. A recomputation under the amended section 215(f)(2) will be effective, in the case of a living beneficiary, with January of the year following the year in which the earnings were received, and in death cases it will be effective for survivors' benefits beginning with the month of death.

Section 302(d)(2) repeals paragraphs (3), (4), and (7) of section 215(f) of the act, thereby eliminating the provisions for a recomputation to include earnings in the year of entitlement to benefits or in the year in which an individual's benefits were recomputed on account of additional earnings, the provisions for a recomputation for the purpose of paying benefits to survivors of an individual who died after 1960 and who had been entitled to old-age insurance benefits, and the provision for recomputing at age 65 the benefits of an individual who became entitled to benefits before that age. All of these are replaced by the automatic recomputation provision.

Recomputation of disability insurance benefits

Section 302(e) of the bill amends section 223(a)(2) of the act so that the provisions for computing disability insurance benefits will conform with the changed provisions for computing old-age insurance benefits.

Effective dates and saving provisions

Section 302(f)(1) of the bill provides that the repeal of section 215(e)(3) of the act made by section 302(c) (pertaining to recomputations for certain self-employed people) will be effective for individuals who become entitled to benefits after 1965.

Section 302(f)(2) provides that in any case where an individual would, by filing an application prior to January 2, 1966, be entitled to have his benefit recomputed under the provisions of existing law, the individual will be deemed to have filed an application on the date of enactment of the bill or the earliest date of eligibility thereafter and prior to January 2, 1966. Thus anyone who would profit from a recomputation under the provisions of present law will have his benefit amount recomputed automatically as though he had filed an application for that recomputation. The new automatic recomputation provisions will take over for the future.

Section 302(f)(3) retains paragraphs (3) and (4) of section 215(f) of present law for the purpose of providing, for survivors' benefits, a recomputation of the primary insurance amount of an individual who was entitled to an old-age insurance benefit and who died after 1960 and before 1966 without having filed an application for a recomputation. The new recomputation provisions will apply to deaths occurring after 1965.

Section 302(f)(4) retains until 1966 section 215(f)(7) of the act, which provides for the automatic recomputation of benefits to take account of earnings a man who is receiving actuarially reduced benefits may have had after entitlement and through the year of death or attainment of age 65. After 1965, these recomputations will be made under the new automatic recomputation provisions.

Section 302(f)(5) provides that the amendments made by section 302(e) (relating to computations of disability insurance benefits) will apply to individuals who become entitled to disability insurance benefits after 1965.

Section 302(f)(6) retains the provisions for figuring the average monthly wage which were in effect prior to the Social Security Amendments of 1960 so that an individual who was eligible for old-age insurance benefits before 1961 but who became entitled to benefits or died after 1960 can have his average monthly wage figured over less than 5 years of earnings where such a computation will result in a higher primary insurance amount. (Generally, under the Social Security Amendments of 1960, at least 5 years have to be used in the computation of the average monthly wage.)

SECTION 303. DISABILITY INSURANCE BENEFITS

Under existing law, the term "disability" is defined as inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration.

Section 303(a) of the bill amends clause (A) of the first sentence of section 216(i)(1), and paragraph (2) of section 223(c), of the Social Security Act, by striking out in both provisions the requirement that the individual's impairment be one which can be expected to result in death or to be of long-continued and indefinite duration.

Paragraph (1) of section 303(b) of the bill amends (and recodifies) paragraph (2) of section 216(i) of the Social Security Act to provide that a period of disability will end with the second month after the month in which disability ceases (as under existing law) if the individual has been under a disability continuously at least 18 months, but that such period will end with the first month after such cessation where he has been under a disability for a continuous period of less than 18 months. The new paragraph (2) also eliminates the present requirement that the individual must be under a disability when his application for a period of disability is filed and substitutes instead the requirement that no application for a disability determination which is filed more than 12 months after the month in which a period of disability would end (as specified in this section) shall be accepted.

Paragraph (2) of section 303(b) of the bill makes conforming changes in section 216(i)(3) of the Act.

Paragraph (3) of section 303(b) of the bill amends paragraph (1) of section 223(a) of the Act to provide that an individual who is insured for disability insurance benefits (as determined under subsection 223(c)(1)), has not attained age 65, and has filed application for disability insurance benefits is entitled to a disability insurance benefit for each month in his disability payment period (a new term which is defined in sec. 223(d), added by sec. 303(c) of the bill). This amendment eliminates the requirement in present law that an individual must be under a disability when he files his application for disability insurance benefits. In view of the change in the definition of disability and the provision in present law granting 12 months retroactivity to applications, this amendment permits the payment of benefits in those cases of extended disability which terminated before an application was filed. Thus, benefits will be paid for months of

disability even though at the time of filing application the disability has ceased so long as such months of disability fall within the period of retroactivity of the application.

Paragraph (4) of section 303(b) of the bill amends section 223(c)(3)(A) of the Act to eliminate the requirement that the individual must be under a disability which continues until his application for disability insurance benefits is filed. This amendment conforms to the amendment made by section 303(b)(3) of the bill, which eliminates the need for the existence of disability at the time the application was filed.

Section 303(c) of the bill amends section 223 of the Social Security Act by adding a new subsection (d) which defines the term "disability payment period."

Paragraph (1) of the new subsection (d) provides that, for purposes of section 223, the term "disability payment period" means the period beginning with the last month of the individual's waiting period and ending with the month preceding whichever of the following months is the earliest: the month in which he dies, the month in which he attains age 65, or either the second month following the month in which his disability ceases if he has been under a disability for a continuous period of less than 18 calendar months or the third month following the month in which his disability ceases if he has been under a disability continuously for at least 18 calendar months. Under the amendment, three substantive changes are made in existing law. One change permits entitlement to benefits to begin with the 6th month of the waiting period—1 month earlier than under present law under which entitlement to disability benefits cannot begin earlier than the first month after the waiting period. The second change is to provide for benefits only for 2 additional months (as against 3 additional months under present law)—the month in which the disability ceased and the subsequent month—where the disability lasted less than 18 months. Where the disability lasted at least 18 months present law is retained by providing an adjustment period of 3 months' benefits. The third change is to eliminate the requirement that a disability benefit terminates with the month before the first month for which the individual is entitled to old-age insurance benefits. This is a conforming change made necessary by section 304(a) of the bill under which a disability insurance benefit may be paid after the individual becomes entitled to old-age insurance benefits.

Paragraph (2) of the new subsection (d) provides that if an individual had a period of disability which lasted at least 18 calendar months and which ceased within the 60-month period preceding the first month of his waiting period and such individual applies for disability insurance benefits on the basis of a disability which, at the time of application, can be expected to last at least 12 months or to result in death, then for purposes of section 223 the term "disability payment period" includes each month in the waiting period with respect to which such application was filed.

Paragraphs (1), (2), and (3) of section 303(d) of the bill make conforming changes in sections 222(c)(5), 223(a)(2)(B), 223(b), and 202(j)(1) of the Social Security Act. Paragraph (3) further amends section 223(b) to take into account the amendment made by section 303(b)(3) of the bill, which eliminates the need for the individual to be

under a disability at the time application is filed. The paragraph also amends section 202(j)(1) of the act to make it clear that a disability benefit payable under section 223 will be reduced so as not to render erroneous benefits paid prior to the filing of an application for disability benefits. This is in conformity with the amendment made by section 304 of the bill under which a larger benefit can become payable for prior periods during which other benefits had already been paid.

Paragraph (1) of section 303(e) of the bill provides that the amendments made by subsection (a) (eliminating the requirement that the individual's impairment be one that is expected to be of long-continued and indefinite duration or to result in death), by paragraphs (3) and (4) of subsection (b) (relating to eligibility for disability insurance benefits), and by paragraph (3) of subsection (d) (relating to such eligibility after termination of a period of disability) of section 303 of the bill, and subparagraphs (B), (E), and (F) of section 216(i)(2) of the Social Security Act as amended by subsection (b)(1) of section 303 (relating to establishing periods of disability), will be effective with respect to applications under sections 223 and 216(i) of the Social Security Act filed in or after the month in which the bill is enacted, or with respect to applications filed before such month if the applicant has not died before such month and if either (1) notice of the final decision of the Secretary has not been given to the applicant before such month, or (2) such notice has been so given before such month but a civil action thereon is commenced (whether before, in, or after such month, under section 205(g) of the Social Security Act and the decision in such civil action has not become final before such month. However, no monthly insurance benefits under title II of the Social Security Act are to be payable or increased by reason of the amendments made by subsections (a) and (b) of section 303 of the bill for months before the second month after the month of enactment of the bill. Periods of disability as defined in section 216(i)(2) of the Social Security Act may be established on the basis of the modified definition of disability even though such periods commence before the enactment of the bill.

Paragraph (2) of section 303(e) of the bill provides that the new section 223(d)(1) of the Social Security Act (relating to disability payment periods) will be applicable in the case of applications for disability insurance benefits filed by individuals the last month of whose waiting period occurs after the month of enactment of the bill. Those individuals whose waiting periods begin before the enactment of the bill will obtain the benefit of this amendment if the 6th month of their waiting period comes no earlier than the month after the month of enactment. Subparagraph (C) of such section 223(d)(1) (relating to the month in which disability payment periods end) applies to individuals entitled to disability insurance benefits whose disability ceases in or after the second month after the month of enactment of the bill. Thus, the reduction from 3 months to 2 months in cases of disabilities lasting less than 18 months will not apply to any cases where the disability ceased before such second month.

Paragraph (3) of section 303(e) of the bill provides that the new section 223(d)(2) of the Social Security Act (relating to second disabilities), and the conforming amendments made by subsection (d) of the bill, will be effective with respect to applications for disability

insurance benefits and for a disability determination filed after the month of enactment of the bill.

Paragraph (4) of section 303(e) of the bill provides that section 216(i)(2)(D) of the Social Security Act as amended by subsection (b)(1) of the bill (relating to the termination of a period of disability) will be effective with respect to a disability (as defined in sec. 216(i) of the Social Security Act as amended by the bill) which ceases in or after the second month following the month of enactment of the bill.

SECTION 304. PAYMENT OF DISABILITY INSURANCE BENEFITS AFTER ENTITLEMENT TO OTHER MONTHLY INSURANCE BENEFITS

Section 304 of the bill provides that an individual under age 65 may become entitled to disability insurance benefits after having become entitled to old-age, wife's, husband's, widow's, widower's, or parent's insurance benefits; this is not possible under existing law.

Section 304(a) adds a new paragraph (4) to section 202(k) of the Social Security Act to provide that a worker who is simultaneously entitled to both an old-age insurance benefit and a disability insurance benefit for any month will be entitled to receive only the disability insurance benefit for that month.

Section 304(b) changes the heading of section 202(q) of the act (relating to actuarial reduction of benefits) to include a reference to the reduction of disability insurance benefits and widow's insurance benefits (a reference to the latter is required because of the provision for payment of reduced benefits to widows at age 60 which is added to the act by sec. 307 of the bill).

Section 304(c) of the bill adds a new paragraph (2) to section 202(q) of the act and renumbers the present paragraphs (2) through (7) as paragraphs (3) through (8). The new paragraph (2) provides that if an individual is entitled to a disability insurance benefit after having been entitled to a reduced old-age insurance benefit, the disability insurance benefit (determined under sec. 223) will be reduced by the amount by which the old-age insurance benefit would have been reduced if the worker had reached age 65 in the month in which he most recently became entitled to the disability insurance benefit. For example, if a man became entitled at exact age 62 to a reduced old-age insurance benefit of \$80 (based on a primary insurance amount of \$100) and became entitled at exact age 63 to a disability insurance benefit of \$105 (determined under sec. 223 of the act), the disability insurance benefit would be reduced by \$6.60 (one-third of \$20.00), the amount by which the old-age insurance benefit would have been reduced if the man had reached age 65 at the time when he became disabled. The effect of this provision is to reduce the disability insurance benefit to take account of the number of months for which the man actually got a reduced old-age insurance benefit before he became disabled.

Section 304(d) of the bill changes section 202(q)(3)(B) of the act (which provides for reducing wife's or husband's benefits where the wife or husband is also entitled to old-age benefits) to make the provisions of subparagraph (B) inapplicable for months for which the individual is entitled to a disability insurance benefit as well as a wife's or husband's benefit.

Section 304(e) amends subparagraph (C) of paragraph (3) (as redesignated by the bill) of section 202(q) of the act to provide that where a person is entitled to both a disability insurance benefit and to a reduced wife's, husband's, or widow's insurance benefit, the wife's, husband's, or widow's benefit will be reduced by the sum of: (1) the amount by which the disability insurance benefit was reduced to take account of prior entitlement to a reduced old-age insurance benefit, and (2) the amount by which the wife's, husband's, or widow's benefit would be reduced if it were equal to the amount by which such benefit (prior to any reduction) exceeded the unreduced disability insurance benefit.

Section 304(f) of the bill adds two new subparagraphs (F) and (G) to the redesignated paragraph (3) of section 202(q) of the act to provide for reducing the disability insurance benefit of an individual who becomes entitled to the disability benefit after having become entitled to a widow's benefit which is reduced because it was taken before age 62.

Subparagraph (F) sets forth the method for reducing the disability insurance benefit of a woman who becomes entitled to that benefit *at or after attainment of age 62* and who is entitled for the same month to a reduced widow's benefit. The amount of the reduction in the disability insurance benefit is whichever of the following is larger: (1) the amount by which the disability insurance benefit had been reduced because of prior entitlement to a reduced old-age benefit at age 62 or later, or (2) a sum equal to the amount by which the widow's benefit which the woman was getting at age 62 was reduced plus the amount by which the disability insurance benefit would be reduced (because of prior entitlement to a reduced old-age insurance benefit) if the disability benefit were equal to the excess of the unreduced disability benefit over the unreduced widow's insurance benefit.

Subparagraph (G) sets forth the method for reducing the disability insurance benefit of a woman who becomes entitled to the disability benefit *before attainment of age 62* and after entitlement to a reduced widow's benefit. Her disability insurance benefit will be reduced by the amount by which her widow's benefit would have been reduced if she had attained age 62 in the first month for which she became entitled to the disability insurance benefit.

Section 304(g) of the bill makes a conforming change in section 202(q)(4)(A) (as redesignated by the bill) to apply, to a person who is entitled to a disability insurance benefit which is reduced because of prior entitlement to a reduced benefit, the present provisions which set forth the method for reducing increases in benefits which occur after the person has come on the rolls and before he reaches age 65.

Section 304(h) of the bill adds a new subparagraph (F) to paragraph (7) (as redesignated by the bill) of section 202(q) of the act to provide that, in determining the "adjusted reduction period" (that is, the number of months in the reduction period for which a reduced benefit was actually paid and for which the old-age insurance benefit will be reduced for future months) applicable to a reduced old-age insurance benefit, any month for which a disability insurance benefit was payable will be excluded.

Section 304(i) of the bill is a conforming change in the redesignated paragraph (8) of section 202(q) to apply to the reduced disability

insurance benefit the provision in existing law for reducing the amount of the reduction to the next lower multiple of 10 cents if it is not already a multiple of 10 cents.

Section 304(j) of the bill makes a technical conforming change in paragraph (2) of section 202(r) of the act (relating to the presumed filing of application by individuals eligible for old-age insurance benefits and for wife's or husband's insurance benefits).

Section 304(k) of the bill amends section 215(a)(4) of the act, which provides a method of determining the primary insurance amount of an individual entitled to a disability insurance benefit who dies, or becomes entitled to an old-age insurance benefit (in the case of a woman) or attains age 65 (in the case of a man). Under existing law the primary insurance amount in such cases is equal to the disability insurance benefit; this provision operates properly under existing law because the disability insurance benefit is never reduced and thus is always equal to the primary insurance amount. Under the bill, however, the disability insurance benefit may be reduced and therefore smaller than the primary insurance amount. Section 304(k) therefore provides that the primary insurance amount to be used in the case where a disability beneficiary dies or becomes entitled to old-age insurance benefits or attains age 65 shall be the primary insurance amount on which the disability insurance benefit was based rather than the amount of the disability insurance benefit itself.

Section 304(l) of the bill amends paragraph (2) of section 216(i) of the act to remove a reference to section 223(a)(3) which is repealed by section 304(n) of the bill.

Section 304(m) of the bill makes a conforming change in paragraph (2) of section 223(a) to take account of the reduction of the disability insurance benefit under the provisions of section 202(q) as amended by the bill.

Section 304(n) of the bill repeals paragraph (3) of section 223(a) of the act, thereby permitting an individual to become entitled to a disability insurance benefit after having become entitled to a widow's, widower's, parent's, old-age, wife's, or husband's insurance benefit.

Section 304(o) of the bill provides that the amendments made by section 304 are to apply with respect to monthly benefits for and after the second month following the month of enactment of the bill on the basis of applications in or after such month of enactment.

SECTION 305. DISABILITY INSURANCE TRUST FUND

Section 305(a) of the bill amends section 201(b)(1) of the Social Security Act to increase the percentage of taxable wages appropriated to the disability insurance trust fund (now one-half of 1 percent) to three-fourths of 1 percent, effective with respect to wages paid after 1965.

Section 305(b) of the bill amends section 201(b)(2) of the Social Security Act to increase the percentage of taxable self-employment income appropriated to the disability insurance trust fund (now three-eighths of 1 percent) to nine-sixteenths of 1 percent, effective with respect to taxable years beginning after 1965.

SECTION 306. PAYMENT OF CHILD'S INSURANCE BENEFITS AFTER ATTAINMENT OF AGE 18 IN CASE OF CHILD ATTENDING SCHOOL

Section 306(a) of the bill amends subparagraph (B) of section 202(d)(1) of the Social Security Act to provide for the payment of benefits to a child up to the age of 22 if he is attending school. The amended subparagraph (B) also contains language relating to a child who is over 18 but who is unmarried and under a disability which began before he attained age 18 which conforms to the revised definition of disability in section 223(c) of the Social Security Act as amended by section 303(a)(2) of the bill. A child will be considered to be under a disability if the disability began before he attained the age of 18 and lasted, or could be expected to last, for a continuous period of at least 6 calendar months or to result in his death.

Subsection (b)(1) of section 306 amends the first sentence of section 202(d)(1) of the Social Security Act (relating to the termination of child's benefits) by adding six new subparagraphs. The new subparagraphs (D) and (E) retain the provisions of existing law which terminate a child's benefit if he marries, dies, or is adopted (except for adoption by certain relatives) and provide in general for the termination of the child's benefits at attaining age 18 if he is no longer attending school and is not under a disability.

The new subparagraph (F) provides that benefits for a child who is not disabled and is a full-time student in the month in which he attains age 18 will terminate with the last month in which he is a full-time student or the month before the month in which he attains age 22, whichever occurs first.

The new subparagraph (G) provides that benefits for a child who becomes entitled to benefits after he attains age 18 and is not disabled will end with the last month in which he is a full-time student or the month before the month in which he attains age 22, whichever occurs first.

The new subparagraph (H) provides that if a child ceases to be under a disability which began before he attained age 18 and which lasted for a continuous period of at least 18 months, and the child either attains age 22 before the close of the third month following the month in which his disability ceases or is not a full-time student during that month, his benefits will terminate with the month before such third month. However, if the child's disability lasted less than 18 months, and he either attains age 22 before the close of the second month following the month in which his disability ceases or is not a full-time student in that month, his benefits will terminate with the month before such second month.

The new subparagraph (I) provides that if a child's disability ceases after he attains age 18 but before he attains age 22, and if he is a full-time student in the third month (or second month, if his disability lasted less than 18 months) thereafter, his benefits will terminate with the last month in which he is a full-time student or the month before the month in which he attains age 22, whichever occurs first.

Subsection (b)(2) of section 306 repeals a sentence which is no longer needed because it has been incorporated in the changes made by subsection (b)(1).

Subsection (b)(3) of section 306 adds two new paragraphs, (7) and (8), to section 202(d) of the act. The new paragraph (7) permits a child whose benefits are terminated after he attains age 18 to become reentitled to child's insurance benefits, on filing a new application, if he becomes a full-time student before age 22. Such reentitlement to benefits will end with the last month in which he is a full-time student or the month before the month in which he attains age 22, whichever occurs first.

The new paragraph (8) defines "full-time student" and "educational institution." A full-time student is an individual who is in full-time attendance at an educational institution; whether or not the student was in full-time attendance is to be determined by the Secretary in the light of the standards and practices of the school involved. Specifically excluded from the definition of "full-time student" is a person who is paid by his employer while attending school at the request (or pursuant to a requirement) of his employer. Benefits are payable for any period of 4 calendar months or less in which a person does not attend school if the person shows to the satisfaction of the Secretary that he intends to continue in full-time school attendance immediately after the end of the period, or if the person is in fact in full-time attendance immediately after the end of the period.

The definition of "educational institution" includes all public schools, colleges, and universities, and all private schools, colleges, and universities which are accredited by a State recognized or nationally recognized accrediting association. Also included are those nonaccredited schools, colleges, and universities whose credits are accepted, on transfer, by three accredited institutions on the same basis as if transferred from an accredited institution.

Subsection (c)(1) of section 306 of the bill adds a new subsection (s) to section 202 of the act. Paragraph (1) of the new subsection (s) prevents a wife, widow, or surviving divorced mother from getting benefits if the only child in her care is getting benefits solely because he is a student.

Paragraph (2) of the new subsection (s) revises the provisions of law which permit a person with a childhood disability to continue to get benefits when he marries another beneficiary, and which permit such a beneficiary to continue to get benefits when he marries a person with a childhood disability. Benefits are payable if the child was under a disability which began before he attained age 18 or had been under such a disability in the third month before the month in which such marriage occurred.

Paragraph (3) of the new subsection (s) retains the provision in existing law which permits a person entitled to benefits because of a childhood disability to become entitled to a higher spouse's benefit without meeting the generally applicable dependency requirement.

Subsections (c)(2) through (c)(13) of section 306 make conforming changes to incorporate references to the new subsection (s).

Subsections (c)(14) and (c)(15) of section 306 provide that the provisions of existing law which relate to withholding of benefits payable to a person with a childhood disability while an investigation of whether his disability still exists is being made or when he refuses to accept vocational rehabilitation services will not apply with respect to children over 18 who are attending school.

Subsection (d) of section 306 provides that the amendments made by that section will be effective for January 1965 and months thereafter on the basis of applications for benefits filed in or after the month of enactment of the bill. Where a child was already on the rolls in the month the bill is enacted no application will be required.

SECTION 307. REDUCED BENEFITS FOR WIDOWS AT AGE 60

Widow's insurance benefits payable beginning at age 60

Section 307(a)(1) of the bill amends section 202(e) of the Social Security Act to provide that a widow may become entitled at age 60 to benefits based on the earnings record of her deceased husband. Section 307(a)(2) of the bill, by providing for the application to the benefits of section 202(q), provides that the benefits payable to widows who claim them before age 62 will be reduced to take account of the longer period over which they will be paid. Under existing law, unreduced benefits equal to 82½ percent of the deceased husband's primary insurance amount are payable to a widow at or after age 62.

Reduction factors

Section 307(b)(1) of the bill amends section 202(q)(1) of the Social Security Act, governing the reduction of benefits payable to beneficiaries who elect to start getting them prior to attainment of age 65, to provide that widow's insurance benefits to which a woman is entitled for a month before she is 62 are reduced by five-ninths of 1 percent for each month in the reduction period (the months prior to attainment of age 62 for which she is entitled to a widow's benefit) and that benefits to which she is entitled for the month in which she attains age 62 and months thereafter are reduced by the same percentage for each month in the adjusted reduction period (the months prior to attainment of age 62 for which the widow has actually been paid a benefit). This is the same factor as that which applies to an old-age benefit which is payable prior to attainment of age 65. Under the amendment, the benefits provided for a widow before age 62 may be reduced for as many as 24 months. The reduction for a widow claiming her benefit at exactly age 60 would be 13⅓ percent; her benefit would be reduced from the 82½ percent of her husband's primary insurance amount which would be payable to her at age 62 to 71½ percent of such primary insurance amount. For a widow who gets reduced benefits, the amount of the reduction in benefits would be adjusted at age 62 (as it is now adjusted at age 65 for old-age, wife's, or husband's benefits) to take account of any months in which no benefit was paid.

Entitlement to benefits on own earnings record

Paragraphs (2) and (3) of section 307(b) of the bill amend section 202(q)(3) (as renumbered by the bill) of the act to provide that where a widow is entitled to a disability insurance benefit based on her own earnings when she becomes entitled to a reduced widow's benefit, the reduction in the widow's benefit applies only to the excess of the widow's benefit over the benefit payable on her own earnings record. Similar provision is made under existing law for a person who is entitled simultaneously to a reduced old-age benefit and a wife's or husband's benefit; for example, where a wife is entitled

to a benefit based on her own earnings for the month for which she first becomes entitled to a wife's benefit the reduction factor applies only to the amount by which the wife's benefit exceeds her own benefit.

Reduction in subsequent old-age insurance benefit

Section 307(b)(4) of the bill adds a new subparagraph (E) to section 202(q)(3) (as renumbered) of the act to provide a method for reducing the old-age insurance benefit of a widow who is entitled to reduced widow's benefits. The old-age benefit (whether the woman begins to get it before or after she reaches age 65) will be reduced to take account of the widow's benefits paid to her before age 62. The amount of the reduction in the old-age benefit is whichever of the following is larger: (1) the reduction which would have been made in the old-age benefit if no widow's benefit had been payable, or (2) the dollar amount of the reduction in the widow's benefit plus the amount resulting from applying to the amount by which the unreduced old-age benefit exceeds the unreduced widow's benefit the reduction factor which would have been applied to the unreduced old-age benefit if the woman had not been eligible for a reduced widow's benefit.

The operation of this provision may be illustrated by the following example: Assume that a woman upon reaching age 60 elects to start getting a widow's benefit and that the benefit is reduced from \$50.40 (82½ percent of her husband's primary insurance amount) to \$43.70—a \$6.70 reduction (24 months times five-ninths of 1 percent, or 13½ percent of \$50.40). Assume further that at age 64 she becomes entitled to an unreduced old-age benefit of \$76. If no widow's benefit had been payable, the \$76 benefit would have been reduced to \$71—a \$5.00 reduction (12 months times five-ninths of 1 percent, or 6⅔ percent of \$76). Under the new section 202(q)(3)(E), the amount by which her unreduced old-age benefit exceeds her unreduced widow's benefit, or \$25.60 (the \$76 old-age benefit less the \$50.40 widow's benefit), will be reduced to \$23.90—a \$1.70 reduction (6⅔ percent of \$25.60). Since the sum of the amount of the reduction in her widow's benefit and the reduction in her excess old-age benefit—\$8.40 (\$6.70 plus \$1.70)—is larger than the amount by which her old-age insurance benefit would have been reduced—\$5.00—her old-age benefit must be reduced by the larger amount—\$8.40—that is, from \$76 to \$67.60.

Reduction where widow has a child in her care

Section 307(b)(5) of the bill adds to section 202(q)(5) (as renumbered) of the act a new clause, (D), to provide that, regardless of the provisions for reducing the benefits of widows who claim them before age 62, in no case will a widow who had in her care a child entitled to child's benefits get less in benefits for months in which she had the child in her care than the amount of the mother's insurance benefit (75 percent of her husband's primary insurance amount). This could happen, for example, where a widow started getting widow's benefits at age 60 (71½ percent of her husband's primary insurance amount) and starting at age 61 a child entitled to benefits was placed in her care. This provision permits her benefit amount for any month in which she has a child in her care to be increased to 75 percent of her husband's primary insurance amount.

Reduction period

Section 307(b)(6) of the bill amends section 202(q)(6) (as renumbered) of the act to provide that, in the case of widow's insurance benefits, the "reduction period" will begin with the first month for which the woman is entitled to a reduced widow's benefit and will end with the month before the month in which she attains age 62. The number of months in the "reduction period" is the number that is multiplied by five-ninths of 1 percent to determine the reduction in the benefits.

Adjusted reduction period

Section 307(b)(7) of the bill amends section 202(q)(7) (as renumbered) of the act, which describes the months which will be eliminated from the "reduction period" in determining the "adjusted reduction period" for purposes of establishing the benefit amount payable for months beginning with the month after the reduction period, to provide that, in determining a widow's adjusted reduction period at age 62, months in which her reduced widow's benefit was increased because she had in her care a child of her deceased husband entitled to child's insurance benefits, months in which her benefit was withheld because she had earnings from work, and months beginning with the month the widow's benefit was terminated through the month prior to the widow's attainment of age 62, will not be counted. For example, if a widow elects to start getting benefits upon reaching age 60 her benefit amount will be reduced by five-ninths of 1 percent for each of the 24 months in the reduction period; if, starting at age 61, a child entitled to a benefit is placed in the widow's care and remains in her care for 6 months, her benefit amount will be adjusted at age 62 and, for future months, will be reduced by five-ninths of 1 percent for each of the 18 months in the adjusted reduction period.

Definitions

Section 307(b)(8) of the bill adds a new paragraph (9) to section 202(q) of the act. The new paragraph defines "retirement age", for purposes of the actuarial reduction provisions, as age 65 for old-age, wife's, or husband's insurance benefits and age 62 for widow's insurance benefits.

Effective date

Section 307(c) of the bill provides that reduced widow's insurance benefits will be payable beginning with the second month after the month of enactment of the bill on the basis of applications filed in or after the month of enactment.

SECTION 308. WIFE'S AND WIDOW'S BENEFITS FOR DIVORCED WOMEN

Section 308(a) of the bill amends section 202(b) (relating to the payment of wife's insurance benefits) of the Social Security Act to provide for the payment of wife's insurance benefits to a divorced wife who had not remarried and who met the following support requirements at the time her former husband became entitled to old-age or disability insurance benefits, or at the time his period of disability began: (1) she was receiving at least one-half of her support from her former husband, (2) she was receiving substantial contributions

from him (pursuant to a written agreement), or (3) there was in effect a court order for substantial contributions to her support from him. The amended section 202(b) also provides that a wife's benefits will not terminate if she has attained age 62 and is divorced after having been married for 20 years (benefits for a wife under age 62 with a child in her care would terminate if she was divorced, regardless of how long she had been married, since benefits are not provided for a young divorced wife with a child in her care until after the former husband's death). The amended section 202(b) also adds to the present provisions for terminating wife's benefits a provision for terminating a divorced wife's benefit if she marries someone other than the worker on whose earnings her benefit is based. For purposes of paying benefits to a divorced wife, a remarriage which ended in a divorce after less than 20 years would be deemed not to have occurred. (Benefits will not be payable under this provision, for deeming the marriage not to have occurred, for any month before whichever of the following is the latest: The month after the month in which the divorce occurs; the 12th month before the month in which these benefits are applied for; or the 2d month after the month of enactment of the bill.) Also, if a divorced wife married a person entitled to benefits as a widower, parent, or disabled child, her benefits (and her new husband's benefits) would not be terminated, and if she married a person getting old-age or disability insurance benefits, she would immediately become eligible for wife's benefits based on her new husband's wages and self-employment income.

Section 308(b)(1) amends section 202(e) (relating to the payment of widow's insurance benefits) of such act to provide for the payment of widow's insurance benefits to a surviving divorced wife who had not remarried and who met the following support requirements at the time her former husband died, at the time he became entitled to old-age or disability benefits, or at the beginning of a period of disability which ended with his death or entitlement to monthly benefits: (1) she was receiving at least one-half of her support from her former husband, (2) she was receiving substantial contributions from him (pursuant to a written agreement), or (3) there was in effect a court order for substantial contributions to her support from him.

Sections 308(b)(2) and 308(b)(3) of the bill make conforming changes in the provisions for paying widow's benefits to a surviving divorced wife so that she will have the same treatment as a widow has under existing law in the event that she marries a beneficiary or a person who dies within 1 year and is not insured.

Section 308(b)(4) of the bill further amends the existing provisions of section 202(e) of the act for paying widow's insurance benefits to provide that, for purposes of paying benefits to widows and surviving divorced wives, a remarriage which ends in divorce after less than 20 years will be deemed not to have occurred. (Benefits will not be payable under this provision, for deeming the marriage not to have occurred, for any month before whichever of the following is the latest: The month after the month in which the divorce occurs; the 12th month before the month in which these benefits are applied for; or the 2d month after the month of enactment of the bill.)

Section 308(c) amends section 216(d) of the Social Security Act to define "divorced wife", "surviving divorced wife", "surviving divorced mother", and "divorce". Paragraphs (1) and (2) of the new subsection (d) define "divorced wife" and "surviving divorced wife" as a

woman divorced from an individual to whom she was married for a period of 20 years immediately before the divorce. The new paragraph (3) of section 216(d) substitutes the term "surviving divorced mother" for the term "former wife divorced" in the definition of the latter term as contained in existing law. Paragraph (4) defines "divorce" and "divorced" as meaning a divorce *a vinculo matrimonii*. Existing law uses the full term wherever divorce is mentioned.

Section 308(d)(1) of the bill deletes a reference to "divorced *a vinculo matrimonii*" which is no longer needed because of the definition of divorce included in the law by section 308(c) of the bill.

Section 308(d)(2) amends the provisions of the Social Security Act for continuing child's, widower's, and parent's benefits if the beneficiary marries a person getting dependents' or survivors' benefits so that such benefits will not terminate if the beneficiary marries a divorced wife getting wife's benefits. Section 308(d)(2) also has the effect of providing that a woman getting benefits as a divorced wife who marries an old-age or disability insurance beneficiary may become eligible for wife's or widow's benefits on the basis of her new husband's wages and self-employment income without regard to the 1-year duration-of-marriage requirement in present law. (Similar treatment is provided for individuals entitled to widow's benefits under existing law.)

Paragraphs (3), (4), and (5) of section 308(d) amend section 202(g) (relating to mother's insurance benefits). Under the amendment made by paragraph (3), the support requirement which must be met if a surviving divorced mother is to qualify for mother's insurance benefits is the same as the new support requirement provided for a "divorced wife" and a "surviving divorced wife." Under the amendment made by paragraph (4), for purposes of paying mother's insurance benefits to a widow or surviving divorced mother, a subsequent marriage which ends in divorce after less than 20 years may be deemed not to have occurred. (Benefits will not be payable under this provision, for deeming the marriage not to have occurred, for any month before whichever of the following is the latest: The month after the month in which the divorce occurs; the 12th month before the month in which these benefits are applied for; or the 2d month after the month of enactment of the bill.) This provision does not preclude payment of mother's insurance benefits on the basis of the wages and self-employment income of a person to whom she was remarried for less than 20 years and from whom she had been divorced if she could become entitled to such benefits under existing law.

Paragraph (5) would replace the present term "former wife divorced" with the term "surviving divorced mother" in section 202(g) of existing law (relating to mother's insurance benefits).

Paragraph (6) of section 308(d) amends section 203(a) (relating to maximum family benefits) to provide that the monthly benefits paid to a divorced wife or a surviving divorced wife will not be reduced because of the limit on total family benefits and will not be counted in figuring the total benefits payable to others on the basis of the wages or self-employment income of the same individual.

Paragraphs (7), (8), (9), (10), and (11) of section 308(d) make conforming changes in various sections of the Social Security Act.

Section 308(e) of the bill provides an effective date for the section. Wife's and widow's insurance benefits for a divorced wife and a surviving divorced wife will be payable beginning with the second

month after the month of enactment of the bill, but, in the case of an individual who was not entitled to benefits in the month after the month of enactment, only on the basis of an application filed in or after the month of enactment.

SECTION 309. TRANSITIONAL INSURED STATUS

Section 309(a) of the bill adds a new section 227 at the end of title II of the Social Security Act (after the new section 226 added by section 101 of the bill) to provide a special insured status for certain individuals now in their seventies or over who are not eligible for benefits under the provisions of present law because they (or their husbands) do not have 6 quarters of coverage.

Subsection (a) of the new section 227 provides that anyone who attains age 72 before 1969 and does not meet the existing insured-status requirements of section 214(a) will nevertheless be insured if he has one quarter of coverage for each year elapsing after 1950 and before the year in which he attained retirement age (65 for men, 62 for women) and if he has not less than 3 quarters of coverage. These provisions will merge gradually into the fully-insured-status provisions of the present law, so that men who attained age 65 and women who attained age 62 after 1956 will have to meet the requirements of present law in order to qualify for benefits. The following table sets forth the quarter-of-coverage requirements under this provision and shows how these requirements merge with the minimum 6 quarters of coverage required under present law:

Men		Women	
Age (in 1965)	Quarters of coverage required	Age (in 1965)	Quarters of coverage required
76 or over.....	3.....	73 or over.....	3.
75.....	4.....	72.....	4.
74.....	5.....	71.....	5.
73 or younger.....	6 or more (same as present law).	70 or younger.....	6 or more (same as present law).

The benefit payable to a person who meets only the transitional requirement will be \$35. The wife of such a person, if she attains age 72 before 1969, will be eligible at age 72 for a wife's benefit of \$17.50.

Subsection (b) of the new section 227 provides benefits for a widow who reaches age 72 before 1969 and whose husband died before 1957 or reached age 65 before 1957 and died before the transitional provisions go into effect. Such a widow could qualify for widow's benefits of \$35 a month if the man had 3, 4, or 5 quarters of coverage, as shown in the following table (which also shows the requirements of present law):

Year of husband's death (or attainment of age 65, if earlier)	Quarters of coverage required under present law	Quarters of coverage required under the bill for a widow attaining age 72 in—		
		1966 or before	1967	1968
1954 or before.....	6.....	3.....	4.....	5.
1955.....	6.....	4.....	4.....	5.
1956.....	6.....	5.....	5.....	5.
1957 or after.....	6 or more.....	6 or more.....	6 or more.....	6 or more.

Subsection (c) of the new section 227 provides that a widow whose husband dies after the transitional provisions go into effect can become entitled to widow's benefits of \$35 a month if she reaches age 72 before 1969, if her husband reached age 65 before 1957, and if he was (or, upon filing an application prior to his death, would have been) entitled to benefits under the transitional provisions.

Section 309(b) of the bill makes the transitional insured status provisions effective for monthly benefits beginning with the second month following the month of enactment of the bill on the basis of applications filed in or after the month of such enactment.

SECTION 310. INCREASE IN AMOUNT AN INDIVIDUAL IS PERMITTED TO EARN WITHOUT SUFFERING FULL DEDUCTIONS FROM BENEFITS

Section 310(a) of the bill amends paragraph (3) of section 203(f) of the Social Security Act by changing the provision in present law under which there is a \$1-for-\$2 reduction (i.e., a \$1 reduction in benefits for each \$2 of earnings) above \$1,200 and up to \$1,700 to provide instead for a \$1-for-\$2 reduction for earnings from \$1,200 to \$2,400. Benefits will continue to be reduced by \$1 for each \$1 of earnings above \$2,400, as they are now for earnings above \$1,700.

Section 310(b) of the bill provides that the change made by section 310(a) will be effective for taxable years ending after 1965.

SECTION 311. COVERAGE FOR DOCTORS OF MEDICINE

Amendments to Title II of the Social Security Act

Removal of exclusion for doctors of medicine

Under existing law, services performed by a self-employed person in the exercise of his profession as a doctor of medicine, or as a member of a partnership engaged in the practice of medicine, are excepted from the term "trade or business" and thus from self-employment coverage under section 211(c)(5) of the Social Security Act. Section 311(a)(1) of the bill amends section 211(c)(5) of the act by removing the exception provided for services performed as a doctor of medicine or as a member of a partnership engaged in the practice of medicine. In general, the effect of this amendment is to extend social security coverage to net earnings derived by an individual from the practice of medicine on his own account or by a partnership of which he is a member.

Section 311(a)(2) of the bill conforms the provisions of the last two sentences of section 211(c) of the act to the amendment made by section 311(a)(1) of the bill.

Removal of exclusion for interns in Federal hospitals

Section 210(a)(6)(C)(iv) of the Social Security Act excludes from the term "employment," and thus from social security coverage, services performed by certain interns, student nurses, and other student employees of hospitals of the Federal Government. Section 311(a)(3) of the bill amends section 210(a)(6)(C)(iv) of the act so as to remove the exclusion insofar as it pertains to medical or dental interns and medical or dental residents-in-training. The effect of this amendment

is to extend social security coverage to such individuals with respect to services performed by them as interns or residents-in-training in the employ of hospitals of the Federal Government.

Removal of exclusion for student interns

Section 210(a)(13) of the Social Security Act excludes from the term "employment," and thus from social security coverage, services performed as an intern in the employ of a hospital by an individual who has completed a 4-year course in a medical school chartered or approved pursuant to State law. Section 311(a)(4) of the bill amends section 210(a)(13) so as to remove this exclusion. The effect of this amendment is to extend social security coverage to such interns unless their services are excluded under provisions other than section 210(a)(13). Thus, the services of an intern are covered if he is employed by a hospital which is not exempt from income tax as an organization described in section 501(c)(3) of the code. If the intern is employed by a hospital which is exempt from income tax and which has a waiver certificate in effect under section 3121(k) of the code, he is not excluded from coverage by section 210(a)(8)(B) of the Social Security Act if coverage was effected under such certificate.

Amendments to the Internal Revenue Code of 1954

Removal of exclusion for doctors of medicine

Under existing law, services performed by a self-employed person in the exercise of his profession as a doctor of medicine, or as a member of a partnership engaged in the practice of medicine, are excepted from the term "trade or business" under section 1402(c)(5) of the Internal Revenue Code of 1954. Section 311(b)(1) of the bill amends section 1402(c)(5) of the code by removing the exception provided for services performed as a doctor of medicine or as a member of a partnership engaged in the practice of medicine. In general, the effect of this amendment is to subject the net earnings derived by an individual from the practice of medicine on his own account or by a partnership of which he is a member to the self-employment tax.

Section 311(b)(2) of the bill conforms the provisions of the last two sentences of section 1402(c) of the code to the amendment made by section 311(b)(1).

Technical amendments

Section 311(b)(3) of the bill conforms the language of sections 1402(e)(1) and 1402(e)(2) of the code to the amendment made by section 311(b)(1).

Removal of exclusion for interns in Federal hospitals

Section 3121(b)(6)(C)(iv) of the Internal Revenue Code of 1954 excludes from the term "employment," and thus from coverage under the Federal Insurance Contributions Act, services performed by certain interns, student nurses, and other student employees of hospitals of the Federal Government. Section 311(b)(4) of the bill amends section 3121(b)(6)(C)(iv) of the code so as to remove the exclusion insofar as it pertains to medical or dental interns and medical or dental residents-in-training. The effect of this amendment is to make the remuneration of such individuals for services performed by them as such interns or residents-in-training in the employ of hospitals

of the Federal Government subject to the Federal Insurance Contributions Act.

Removal of exclusion for student interns

Section 3121(b)(13) of the Internal Revenue Code of 1954 excludes from the term "employment," and thus from coverage under the Federal Insurance Contributions Act, services performed as an intern in the employ of a hospital by an individual who has completed a 4-year course in a medical school chartered or approved pursuant to State law. Section 311(b)(5) of the bill amends section 3121(b)(13) so as to remove this exclusion. The effect of this amendment is to extend coverage under the Federal Insurance Contributions Act to such interns unless their services are excluded under provisions other than section 3121(b)(13). Thus, the services of an intern are covered if he is employed by a hospital which is not exempt from income tax as an organization described in section 501(c)(3) of the code. If the intern is employed by a hospital which is exempt from income tax and which has a waiver certificate in effect under section 3121(k) of the code, he is not excluded from coverage by section 3121(b)(8)(B) of the code if coverage was effected under such certificate.

Effective Date

Section 311(c) of the bill provides that the amendments made by paragraphs (1) and (2) of section 311(a) and by paragraphs (1), (2), and (3) of section 311(b), relating to the self-employment coverage of doctors of medicine, are effective for taxable years ending after December 31, 1965. The amendments made by paragraphs (3) and (4) of section 311(a) and by paragraphs (4) and (5) of section 311(b), relating to social security coverage of interns and residents-in-training, are effective with respect to services performed after 1965.

SECTION 312. GROSS INCOME OF FARMERS

Increasing gross income taken into account for optional method of computing net earnings from farm self-employment; amendments to title II of the Social Security Act

Section 312(a) of the bill amends section 211(a) of the Social Security Act to increase from \$1,800 to \$2,400 the maximum gross income from agricultural activity that a self-employed farmer may use under the optional method of computing his net earnings from self-employment as a farmer. Under present law, an individual whose gross income from agricultural self-employment (including his distributive share of gross income from a farm partnership) is \$1,800 or less may, at his option, base his self-employment coverage on two-thirds of his gross income from farming; if such individual's gross income is more than \$1,800 and his net earnings from self-employment as a farmer are less than \$1,200, he may report \$1,200 as net earnings from self-employment; if his net earnings from self-employment as a farmer are \$1,200 or more, he must report his actual net earnings from self-employment as a farmer. Under the amendments made by section 312(a) of the bill an individual whose gross income from agricultural self-employment (including his distributive share of gross income from a farm partnership) is \$2,400 or less may, at his option, base his self-employ-

ment coverage on two-thirds of his gross income from farming; if he has gross income of more than \$2,400 and net earnings from self-employment of less than \$1,600, he may report \$1,600 as net earnings from self-employment as a farmer; if his net earnings from self-employment as a farmer are \$1,600 or more, he must report his actual net earnings from self-employment as a farmer.

Same: Amendments to the Internal Revenue Code of 1954

Section 312(b) of the bill amends section 1402(a) of the Internal Revenue Code of 1954 to increase from \$1,800 to \$2,400 the maximum gross income from agricultural activity that a self-employed farmer may use under the optional method of computing his net earnings from self-employment as a farmer. Under present law, an individual whose gross income from agricultural self-employment (including his distributive share of gross income from a farm partnership) is \$1,800 or less may, at his option, treat as net earnings from such self-employment two-thirds of his gross income from farming; if such individual's gross income is more than \$1,800 and his net earnings from self-employment as a farmer are less than \$1,200, he may treat \$1,200 as net earnings from self-employment; if his net earnings from self-employment as a farmer are \$1,200 or more, he must report his actual net earnings from self-employment as a farmer. Under the amendments made by section 312(b), an individual whose gross income from agricultural self-employment (including his distributive share of gross income from a farm partnership) is \$2,400 or less may, at his option, treat as net earnings from such self-employment two-thirds of his gross income from farming; if he has gross income from farming of more than \$2,400 and his net earnings from self-employment as a farmer are less than \$1,600, he may report \$1,600 as net earnings from self-employment as a farmer; if his net earnings from self-employment as a farmer are \$1,600 or more, he must report his actual net earnings from such self-employment.

Effective Date

Section 312(c) of the bill provides that the amendments made by sections 312(a) and 312(b) will apply with respect to taxable years beginning after December 31, 1965.

SECTION 313. COVERAGE OF TIPS

Section 313 of the bill provides for treating tips received by an employee in the course of his employment as wages paid by the employer for social security tax and benefit purposes and for the purpose of withholding income tax at source. The provisions of this section have no application to amounts which under existing law constitute wages.

Amendments to Title II of the Social Security Act

Section 313(a)(1) of the bill amends section 209 of the Social Security Act (defining "wages" for social security benefit purposes) by adding a new subsection (1). The new subsection provides that tips do not constitute wages if they are paid in a medium other than cash or if the cash tips received in a calendar month by the employee in the course of his employment by a single employer amount to less than \$20.

Section 313(a)(2) of the bill further amends section 209 of the act by adding a new unnumbered paragraph at the end thereof. The new paragraph provides that tips received by an employee in the course of his employment (which are not excluded from wages under the new sec. 209(l) of the act) are to be considered wages for social security benefit purposes. Such tips are deemed paid to the employee by the employer and are deemed so paid at the time a written statement including such tips is furnished the employer pursuant to section 6053(a) of the Internal Revenue Code of 1954 (added by sec. 313(e) (2) of the bill). Tips not included in a written statement or included in a written statement not furnished the employer by the close of the 10th day following the month of receipt (as prescribed in sec. 6053(a) of the code) are considered to have been paid to the employee at the time the tips are received. Tips constitute wages for social security benefit purposes regardless of whether the tips are received by the employee from a person other than his employer or are paid to the employee by his employer. Only tips received by an employee on his own behalf and not on behalf of another employee constitute wages. Thus, where employees practice tip splitting, the ultimate recipient of the tip (or portion thereof) is the employee who is receiving the tip as wages.

Amendments to the Internal Revenue Code of 1954

Section 313(b) of the bill amends section 451 of the Internal Revenue Code of 1954 (relating to the general rule for determining the taxable year of inclusion of an item in gross income) by adding a new subsection (c). The new subsection provides that for purposes of determining the taxable year for which tips are to be included in gross income for income tax purposes, tips included by an employee in a written statement furnished to his employer in the manner and within the time prescribed in section 6053(a) are deemed received by the employee at the time the statement is furnished. Tips not included in a written statement or included in a written statement which is not furnished as prescribed in section 6053(a) are not affected by this subsection; such tips will continue to be treated as received when actually received but in accordance with the general rule provided in section 451(a).

Section 313(c)(1) of the bill amends section 3102 of the code (relating to deduction by the employer of the employee's social security tax from the employee's wages) by adding a new subsection (c).

Under paragraph (1) of the new subsection (c) the employer is responsible for deducting the employee's social security tax on tips, which constitute wages for social security tax purposes, but only to the extent that such tips are included in a written statement furnished the employer pursuant to section 6053(a), and only to the extent that, at or after the time the statement is furnished and before the close of the 10th day following the month in which the tips were received (the last day on which such a statement could be furnished under sec. 6053(a)), the employer can collect the employee's share of the tax by deducting it from wages (not including tips) of the employee under the employer's control, or from funds turned over to him for that purpose by the employee.

Paragraph (2) of the new subsection (c) provides that if the employee's share of social security tax due on tips included in a written

statement furnished to the employer pursuant to section 6053(a) exceeds the wages (other than tips) of the employee already under the employer's control, the employee must give the employer on or before the 10th day following the month in which the tips are received, an amount of money which when added to the wages under the employer's control will be sufficient to pay the tax.

Paragraph (3) of the new subsection (c) authorizes the Secretary of the Treasury or his delegate to prescribe regulations permitting an employer to (1) estimate the amount of tips an employee will report to him pursuant to section 6053 of the code (added by sec. 313(e)(2) of the bill) for a calendar quarter; (2) determine the amount to be deducted upon each payment of wages (other than tips) during such quarter as if the tips so estimated constituted the actual tips so reported; and (3) deduct upon any payment of wages (other than tips) to such employee during such quarter such amount as may be necessary to adjust the amount of tax withheld to conform to the amount actually due during the quarter (determined without regard to the new paragraph (3)).

Section 313(c)(2) of the bill further amends section 3102 of the code to authorize an employer who is furnished a written statement of tips to withhold the employee social security tax on the tips included in the statement even though at the time it is furnished the total amount of tips included in the statement and prior written statements for the month is less than \$20.

Section 313(c)(3) of the bill amends section 3121(a) of the code (defining "wages" for social security tax purposes) by adding a new paragraph (12). The new paragraph provides that tips do not constitute wages for social security tax purposes if they are paid in a medium other than cash or if the cash tips received in a calendar month by the employee in the course of his employment by a single employer amount to less than \$20.

Section 313(c)(4) of the bill further amends section 3121 of the code by adding a new subsection (q). The new subsection provides that tips received by an employee in the course of his employment (which are not excluded from wages under the new par. (12) of sec. 3121(a)) are to be considered wages, and thus subject to the social security tax. Such tips are deemed paid to the employee by the employer at the time a written statement including such tips is furnished the employer pursuant to section 6053(a). Tips not included in a written statement or included in a written statement not furnished the employer by the close of the 10th day following the month of receipt (as prescribed in sec. 6053(a)) are considered to have been paid to the employee at the time the tips are received. Tips constitute wages for social security tax purposes regardless of whether the tips are received by the employee from a person other than his employer or are paid to the employee by his employer. Only tips received by an employee on his own behalf and not on behalf of another employee constitute wages. Thus, where employees practice tip splitting, the ultimate recipient of the tip (or portion thereof) is the employee who is receiving the tips as wages.

Section 313(d)(1) of the bill amends section 3401 of the code (defining "wages" subject to income tax withholding) by adding a new subsection (f). The new subsection provides that tips received by an employee in the course of his employment, subject to the

exceptions in section 3401(a)(16) of the code (added by sec. 313(d)(2) of the bill), are to be considered wages, and thus subject to withholding of income tax at source. Such tips are deemed paid by the employer to the employee at the time a written statement including such tips is furnished the employer pursuant to section 6053(a). Tips not included in a written statement or included in a written statement furnished to the employer after the time prescribed in section 6053(a) are considered to have been paid to the employee at the time the tips are received. Tips constitute wages for income tax withholding purposes regardless of whether the tips are received by the employee from a person other than his employer or are paid to the employee by his employer. Only tips received by an employee on his own behalf and not on behalf of another employee constitute wages. Thus, where employees practice tip splitting, the ultimate recipient of the tip (or portion thereof) is the employee who is receiving the tips as wages.

Section 313(d)(2) of the bill further amends section 3401 of the code by adding a new paragraph (16) to subsection (a) thereof. The new paragraph provides that tips do not constitute wages subject to income tax withholding if they are paid in a medium other than cash or if the cash tips received in a calendar month by the employee in the course of his employment by a single employer amount to less than \$20.

Section 313(d)(3) of the bill amends section 3402(a) of the code (relating to determining the amount of income taxes the employer is to withhold on wages) by making appropriate reference to new section 3402(k), relative to tips, added by section 313(d)(4) of the bill.

Section 313(d)(4) further amends section 3402 of the code by adding a new subsection (k). The new subsection specifies that the employer is responsible for withholding income tax on tips which constitutes wages for income-tax withholding purposes but only if the tips are included in a written statement furnished the employer pursuant to section 6053(a), and only to the extent that, at or after the time the statement is furnished and before the close of the calendar year in which the tips are received, the employer can collect the tax by deducting it from wages (not including tips) of the employee under the employer's control, or from funds turned over to him for that purpose by the employee, remaining after the employee social security tax has been subtracted. Also, the new subsection authorizes an employer who is furnished a written statement of tips pursuant to section 6053(a) to withhold income taxes on the tips included in such statement, even though at the time it is furnished the total amount of tips included in that statement and prior written statements for the month is less than \$20.

Section 313(e)(1) of the bill amends section 6051(a) of the code (relating to amounts to be shown as "wages" on employee receipts—currently form W-2) by adding a new sentence which provides (1) that the amount to be shown on an employee's receipt as wages subject to social security tax will include tips only to the extent they are included in one or more written statements furnished the employer before the close of the 10th day following the month in which the tips are received, pursuant to section 6053(a), and only to the extent that, at or after the time the statement is furnished and before the close of the last day on which such a statement could be furnished

under section 6053(a), the employer can collect the employee's social security tax from wages (not including tips) of the employee under the employer's control or from funds turned over to the employer by the employee for that purpose; and (2) that the amount to be shown as wages subject to income tax will include tips only to the extent they are included in a timely written statement furnished the employer pursuant to section 6053(a) of the code, irrespective of whether or not the employer was able to deduct and withhold the income tax before the close of the calendar year.

Section 313(e)(2) of the bill amends subpart C of part III of subchapter A of chapter 61 of the code (relating to the information regarding wages paid employees) by adding a new section 6053.

Subsection (a) of the new section 6053 requires every employee who receives tips which constitute wages for social security tax purposes or income tax withholding purposes to furnish to his employer, in accordance with regulations prescribed by the Secretary of the Treasury or his delegate, one or more written statements of his tips before the close of the 10th day following the month in which the tips were received. The Secretary of the Treasury is authorized to prescribe regulations under which employers may require employees to furnish statements more frequently than once a month. He may also prescribe the form in which the employee statements of tips will be made to the employer.

Subsection (b) of the new section 6053 provides that the tips to be taken into consideration—

(1) for purposes of the employer's obligation to collect the employee's share of the tax, pay the employer's share of the tax, and show the wages as being subject to social security tax on an employees' receipt (form W-2), and

(2) for purposes of imposing the penalty, provided by new section 6652(c) of the code (added by sec. 313(e)(3) of the bill), on an employee for failure to report tips and make available his share of the social security tax due on such tips,

are only those tips which are included in a statement furnished the employer pursuant to subsection (a) of section 6053 and only to the extent that, at or after the time the statement is furnished and before the close of the 10th day following the month in which the tips were received, the employer can collect the employee's share of the social security tax from the employee's wages (other than tips) or from other funds turned over by the employee for this purpose pursuant to section 3102(c).

Section 313(e)(3) of the bill amends section 6652 of the code (relating to failure to file certain information returns) by adding a new subsection (c). The new subsection provides that the employee will be required to pay, with respect to tips which he failed to include in a timely written statement to his employer pursuant to section 6053(a) or which he included in a timely written statement but did not make available his share of the social security tax pursuant to section 3102(c), both the employee tax imposed by section 3101 on such tips and an additional amount equal to the employee tax, unless it is shown that the employee's failure was due to reasonable cause and not due to willful neglect.

Section 313(f) of the bill amends section 3111 of the code (relating to the imposition of the social security tax on employers) by adding a

sentence to provide that the employer is liable for paying the employer social security tax only on those tips which are included in a timely written statement furnished him pursuant to section 6053(a), and on which, pursuant to section 3102(c), the employer can collect the employee social security tax, on or after the time the statement is furnished and before the close of the last day on which such a statement could be furnished under section 6053(a), from wages (not including tips) of the employee under the employer's control or from funds turned over to the employer by the employee for that purpose.

Section 313(g) of the bill provides that the amendments made by section 313 of the bill will be effective only with respect to tips received by employees after 1965.

SECTION 314. INCLUSION OF ALASKA AND KENTUCKY AMONG STATES PERMITTED TO DIVIDE THEIR RETIREMENT SYSTEMS

Section 314 of the bill amends section 218(d)(6)(C) of the Social Security Act by adding Alaska and Kentucky to the list of States which are permitted to divide their retirement systems into two divisions for coverage purposes, one division consisting of those members desiring coverage under the act and the other consisting of those who do not, with all new members being covered on a compulsory basis.

SECTION 315. ADDITIONAL PERIOD FOR ELECTING COVERAGE UNDER DIVIDED RETIREMENT SYSTEM

Section 315 of the bill amends section 218(d)(6)(F) of the Social Security Act to grant an additional opportunity to obtain coverage to State and local employees (in a State permitted to use the divided retirement system procedure) who had not previously chosen coverage under the divided retirement system provisions. The present law allows such employees a further opportunity to elect coverage only if a modification providing for such election is mailed or otherwise delivered to the Secretary before 1963, or, if later, 2 years after the date on which coverage was approved for the group that originally elected coverage. Any coverage elected after the original division must begin on the same date as was provided when the group was originally covered. Section 315 extends the time in which such persons could elect to be covered until the end of 1966 (or, if later, the expiration of 2 years after the date on which coverage was approved for the group that originally elected coverage).

SECTION 316. EMPLOYEES OF NONPROFIT ORGANIZATIONS

Section 316 of the bill amends section 3121(k) of the Internal Revenue Code of 1954 and section 105(b) of the Social Security Amendments of 1960.

Period for which certificate shall apply

Section 316(a)(1) of the bill amends section 3121(k)(1)(B) of the code, which relates to the period for which certificates filed by certain

religious, charitable, etc., organizations for the purpose of waiving exemption from tax under chapter 21 of such code become effective. Under present law, a certificate filed pursuant to section 3121(k) is effective for the period beginning with whichever of the following is designated by the organization:

(1) The first day of the calendar quarter in which the certificate is filed.

(2) The first day of the calendar quarter succeeding such quarter, or

(3) The first day of any calendar quarter preceding the calendar quarter in which the certificate is filed, but such period may not begin earlier than the first day of the 4th calendar quarter preceding the quarter in which such certificate is filed.

This amendment removes the limitation that the period may not begin earlier than the first day of the 4th calendar quarter preceding the quarter in which such certificate is filed (see par. (3) above) and provides, in lieu thereof, that the period may not begin earlier than the first day of the 20th calendar quarter preceding the quarter in which the certificate is filed.

Section 316(a)(2) provides that the amendment made by section 316(a)(1) will apply in the case of any certificate filed under section 3121(k)(1)(A) of the code after the date of enactment of the bill.

Amendment of certificate filed before 1966

Section 316(b) of the bill amends section 3121(k)(1) of the Internal Revenue Code of 1954 by adding a new subparagraph (H). Such subparagraph (H) provides that an organization which files a certificate pursuant to section 3121(k)(1) of the code before 1966 may amend such certificate during 1965 or 1966 to make the certificate effective with the first day of any calendar quarter preceding the quarter for which such certificate originally became effective, except that such date may not be earlier than the 20th calendar quarter preceding the quarter in which such certificate is so amended. Pursuant to the new subparagraph (H), an organization which has filed, prior to 1966, a waiver certificate (without regard to whether the certificate is filed before or after the enactment of the bill) may amend such certificate so as to make it effective with the first day of any calendar quarter preceding the first quarter for which the certificate is effective without amendment. However, such a certificate may not be made effective, through an amendment, for any calendar quarter which begins earlier than the 20th calendar quarter preceding the calendar quarter in which such organization files an amendment to its certificate.

Validation of certain remuneration erroneously reported as wages by nonprofit organizations

Section 316(c)(1) of the bill amends section 105(b) of the Social Security Amendments of 1960, which provided that an employee of a nonprofit organization could, under certain circumstances, receive social security credit for remuneration erroneously reported on his behalf by the organization in any taxable period from January 1, 1951, through June 30, 1960. Section 105(b) of the Social Security Amendments of 1960, as amended by the bill, will (where the conditions prescribed by the amendment are met) permit the validation of erroneously reported wages of workers who cannot be covered

through the filing of a waiver certificate by the organization because they are no longer in the employ of the organization when it files its certificate. Under section 105(b), as amended by the bill, remuneration paid to an individual for service before the calendar quarter in which the organization files its waiver certificate under section 3121(k)(1) of the Internal Revenue Code of 1954 may be deemed to constitute remuneration for employment for purposes of title II of the Social Security Act, to the extent that an amount has been paid as social security taxes with respect to such remuneration on or before the due date of the tax return for the calendar quarter before the calendar quarter in which the organization files its waiver certificate. This rule applies, however, only if the service would have constituted employment as defined in section 210 of the Social Security Act if the requirements of section 3121(k)(1) of the Code were satisfied, and only if the following conditions are met:

- (1) the person who performed the service (or a fiduciary acting for him or his estate, or a survivor of such individual who is or may become entitled to monthly benefits under title II of the Social Security Act on his earnings record) makes a request (in such form and manner, and with such official, as the Secretary of Health, Education, and Welfare may by regulations prescribe) that such remuneration be deemed to constitute remuneration for employment for purposes of title II of the Social Security Act;

- (2) a certificate under section 3121(k)(1) of the Internal Revenue Code of 1954 is filed by the organization not later than the date on which the request for validation is made;

- (3) the individual requesting the validation is no longer employed by the organization on the date the organization files its waiver certificate; and

- (4) if any part of the amount paid as social security taxes as previously described with respect to such remuneration paid to an individual is credited or refunded, the amount credited or refunded, plus any interest allowed, must be repaid before January 1, 1968, or, if later, the first day of the third year after the year in which the organization files its waiver certificate.

In addition, the so-called validation of wages is to be permitted only for remuneration received for service which is performed during the period for which an organization's waiver is effective. Thus, former employees of an organization which has made erroneous reports receive no greater retroactive social security coverage than employees who are employed by the organization on the date the organization files its waiver certificate and are covered only for the retroactive period for which the certificate is made effective.

Effective dates of validating provisions

Section 316(c)(2) of the bill provides that the provisions of section 105(b) of the Social Security Amendments of 1960, as amended by the bill, will become effective upon enactment of the bill. The provisions of the existing section 105(b) of the Social Security Amendments of 1960 will continue to apply to requests for validation filed before enactment of the bill. The filing of a request by an individual for validation under the existing provisions of section 105(b) of the Social Security Amendments of 1960 does not bar him from filing another request for validation under section 105(b) as amended by the bill.

SECTION 317. COVERAGE OF TEMPORARY EMPLOYEES OF THE DISTRICT OF COLUMBIA

Sections 317(a) and 317(b) of the bill amend the Social Security Act (sec. 210(a)(7)) and the Internal Revenue Code of 1954 (sec. 3121(b)(7)) to include in the definition of employment services performed by certain temporary employees of the District of Columbia. Under the amendments, service performed in the employ of the District of Columbia, or any wholly owned instrumentality thereof, is included as employment if such service is not covered by a retirement system established by a law of the United States, except that the extension of coverage is not to apply to service performed: (1) in a hospital or penal institution by a patient or inmate thereof, (2) in a hospital of the District of Columbia by student nurses and certain other student employees (other than as a medical or dental intern or as a medical or dental resident-in-training) included under section 2 of the Act of August 4, 1947 (5 U.S.C. 1052), (3) on a temporary basis in certain emergencies, or (4) as a member of a board, committee, or council of the District of Columbia paid on a per diem, meeting, or other fee basis.

Section 317(c) of the bill amends section 3125 of the Internal Revenue Code of 1954 (relating to returns in the case of governmental employees in Guam and American Samoa) by changing the heading thereof and adding a new subsection (c). The new subsection (c) provides that the return and payment of the employee and employer taxes imposed under chapter 21 of the code (Federal Insurance Contributions Act) with respect to services performed as employees of the District of Columbia, or of any wholly owned instrumentality of the District of Columbia, may be made by the Commissioners of the District of Columbia or by such agents as they may designate. A person making such return may, for convenience of administration, make payments of the employer tax imposed under section 3111 without regard to the dollar limitations in section 3121(a)(1) (although this subsection would not authorize such person to disregard these dollar limitations as to remuneration includible in returns made by him). The purpose is to relieve a person making a return on behalf of any department or agency of the District of Columbia or any instrumentality wholly owned thereby, of any necessity for ascertaining whether any wages have been reported for a particular employee by any other reporting unit of such government or instrumentality.

Section 317(d) of the bill amends section 6205(a) of the Internal Revenue Code of 1954 by adding a new paragraph (4). The new paragraph (4) provides that the Commissioners of the District of Columbia and each agent designated by them, pursuant to section 3125 of the code, to make returns of the employee and employer taxes imposed under the Federal Insurance Contributions Act, will be deemed to be a separate employer for purposes of section 6205(a) of the code, relating to adjustments of underpayments of such taxes. Thus, adjustments of underpayments will be made by the reporting unit by which the underpayment was made.

Section 317(e) of the bill amends section 6413(a) of the Internal Revenue Code of 1954 by adding a new paragraph (4). The new paragraph (4) provides that the Commissioners of the District of Columbia and each agent designated by them, pursuant to section

3125 of the code, to make returns of the employee and employer taxes imposed under the Federal Insurance Contributions Act, will be deemed to be a separate employer for purposes of section 6413(a) of the code, relating to adjustments of overpayments of such taxes. Thus, adjustments of overpayments will be made by the reporting unit by which the overpayment was made.

Section 317(f) of the bill amends paragraph (2) of section 6413(c) of the Internal Revenue Code of 1954 by redesignating the heading of such paragraph (2) and by adding to such paragraph (2) a new subparagraph (F). The new subparagraph provides that for purposes of the special credit or refund provisions contained in section 6413(c)(1) of the code, the Commissioners of the District of Columbia and each agent designated by them to make returns of the employee and employer taxes imposed under the Federal Insurance Contributions Act will be deemed to be a separate employer. The effect of this amendment is to permit a claim for special credit or refund, rather than a general claim for refund under section 6402(a), in any case where an employee receives more than the maximum creditable wages in a calendar year by reason of having performed services for two or more reporting units of the District of Columbia or any instrumentality wholly owned thereby.

Section 317(g) of the bill provides that the amendments made by section 317 will apply with respect to service performed after the calendar quarter in which such section is enacted and after the calendar quarter in which the Secretary of the Treasury receives a certification from the Commissioners of the District of Columbia expressing their desire to have the insurance system established by title II (and part A of title XVIII) of the Social Security Act extended to the officers and employees coming under the provisions of such amendments.

SECTION 318. COVERAGE FOR CERTAIN ADDITIONAL HOSPITAL EMPLOYEES IN CALIFORNIA

Section 318 of the bill amends section 102(k) of the Social Security Amendments of 1960 by adding a new paragraph (2) permitting the coverage agreement with the State of California to be modified to apply to certain additional services performed for any hospital affected by any modification (in the California State coverage agreement) executed pursuant to section 102(k). The services which could thus be covered are those performed by individuals who were or are employed by such State (or any political subdivision thereof) after December 31, 1959, in any position described in section 102(k). The State will have until the end of the 6th month after the month of enactment in which to so modify its agreement. Such modification will be effective with respect to services performed on or after January 1, 1962; it will also be effective with respect to services performed before January 1, 1962, where contributions in the proper amount have been paid before the date of enactment of the bill.

SECTION 319. TAX EXEMPTION FOR RELIGIOUS GROUPS OPPOSED TO INSURANCE

Amendment to the Internal Revenue Code of 1954

Section 319(a) of the bill amends section 1402(c) of the code by adding a new paragraph (6) which excepts from the term "trade or

business" the performance of service by individuals who are members of certain religious faiths during the period for which an exemption under the new subsection (h) (as added by sec. 319(c)) of section 1402 is effective with respect to them. The effect of the amendment is to exempt from the self-employment tax an individual who is granted an exemption under section 1402(h) of the code.

Amendment to title II of the Social Security Act

Section 319(b) of the bill amends section 211(c) of the Social Security Act by adding a new paragraph (6) which excepts from the term "trade or business" the performance of service by individuals who are members of certain religious faiths during the period for which an exemption under new subsection (h) (as added by sec. 319(c)) of section 1402 of the Internal Revenue Code of 1954 is effective with respect to them. The effect of the amendment is to remove from social security coverage a self-employed individual who is granted an exemption from tax under section 1402(h) of the code.

Application for exemption from self-employment tax; amendment to the Internal Revenue Code

Section 319 (c) of the bill amends section 1402 of the code by adding a new subsection (h).

Paragraph (1) of section 1402 (h) provides that any individual may file an application (in such form and manner and with such official as may be prescribed by regulations under sec. 1402 (h)) for an exemption from the tax imposed on self-employment income if he is a member of a recognized religious sect or division thereof and is an adherent of established tenets or teachings of such sect or division by reason of which he is conscientiously opposed to the acceptance of the benefits of any private or public insurance making payments in the event of death, disability, old-age, or retirement or making payments toward the cost of, or providing services for, medical care. An individual who applies for exemption must, therefore, among other things, be opposed to all types of benefits or payments under titles II and XVIII of the Social Security Act.

In order that an individual may be granted an exemption from the tax imposed on self-employment income, subparagraph (A) of section 1402(h)(1) provides that the individual's application for exemption must contain, or be accompanied by, such evidence of such individual's membership in, and adherence to the tenets or teachings of, the religious sect or division thereof as the Secretary of the Treasury or his delegate may require for purposes of determining such individual's compliance with the requirements of the first sentence of paragraph (1) of section 1402(h), and subparagraph (B) of such section provides that such application must be accompanied by the individual's waiver of all benefits and other payments under titles II and XVIII of the Social Security Act on the basis of his wages and self-employment income as well as all such benefits and other payments to him on the basis of the wages and self-employment income of any other person.

In addition to the requirements of subparagraphs (A) and (B) relating to the individual who files application for exemption from the tax on self-employment income, subparagraphs (C), (D), and (E) of section 1402(h)(1) provide that an exemption may be granted

only if the Secretary of Health, Education, and Welfare makes the following findings with respect to the religious sect or division thereof of which such individual is a member:

1. That the sect or division thereof has the established tenets or teachings by reason of which the individual applicant is conscientiously opposed to the benefits of certain types of insurance;
2. That it is the practice, and has been for a period of time which the Secretary deems to be substantial, for members of such sect or division thereof to make provision for their dependent members which, in the judgment of the Secretary, is reasonable in view of the general level of living of the members of the sect or division thereof;
3. That the sect or division thereof has been in existence continuously since December 31, 1950.

Section 1402(h)(1) of the code further provides that an exemption from the tax on self-employment income may not be granted to an individual if any benefit or other payment referred to in subparagraph (B) of such section became payable at or before the time of the filing of such waiver. This provision applies if any such benefit or other payment would have become payable at such time but for a reduction of or deduction from such benefit or payment in accordance with the provisions of section 203 (relating to reduction of insurance benefits) or 222(b) (relating to deduction on account of refusal to accept rehabilitation services) of the Social Security Act.

Paragraph (2) of section 1402(h) of the code provides rules relating to the time for filing the application for exemption described in section 1402(h)(1). Subparagraph (A) of section 1402(h)(2) provides that an individual who has self-employment income (determined without regard to the exception contained in sec. 1402(c)(6)) for any taxable year beginning after December 31, 1950 (see sec. 319(e) of the bill, relating to effective date), and ending before December 31, 1965, must file his application for exemption on or before April 15, 1966. Subparagraph (B) of section 1402(h)(2) provides that in any other case an individual must file his application for exemption on or before the due date of the return (including any extension thereof) for the first taxable year ending on or after December 31, 1965, in which he has self-employment income (determined without regard to sec. 1402(c)(6)). If an individual fails to file an application for exemption from the self-employment tax within the time prescribed by section 1402(h)(2) (A) or (B), whichever is applicable in his case, he will not be entitled to the exemption.

Paragraph (3) of section 1402(h) provides that an exemption granted to an individual pursuant to section 1402(h) will apply with respect to all taxable years beginning after December 31, 1950. However, subparagraph (A) of section 1402(h)(3) provides that such exemption will not apply for any taxable year which begins before the taxable year in which the individual who files an application for exemption first became a member of a recognized religious sect or division thereof and was an adherent of established tenets or teachings of such sect or division by reason of which he was conscientiously opposed to the acceptance of the benefits of certain types of insurance. Subparagraph (A) further provides that such exemption will not apply for any taxable year which begins before the date as of which the Secretary of Health, Education, and Welfare finds that the sect or division

thereof of which such individual is a member had the established tenets or teachings referred to in section 1402(h)(1), and that it was the practice of such sect or division to make reasonable provision for its dependent members. Subparagraph (B) of section 1402(h)(3) provides that an exemption granted pursuant to section 1402(h) will cease to be effective for any taxable year ending after the time the individual who files an application for exemption ceases to meet the requirements of the first sentence of section 1402(h)(1), or after the time as of which the Secretary of Health, Education, and Welfare finds that the sect or division thereof of which such individual is a member ceases to have the required tenets or teachings or ceases to make reasonable provision for its dependent members.

Paragraph (4) of section 1402(h) provides that in any case where an individual who has self-employment income dies before the expiration of the time prescribed in section 1402(h)(2) for filing an application for exemption pursuant to section 1402(h), such an application may be filed with respect to such deceased individual within the time prescribed in section 1402(h)(2) with respect to him by a fiduciary acting for such individual's estate or by such individual's survivor (within the meaning of sec. 205(c)(1)(C) of the Social Security Act).

Waiver of benefits; amendment to title II of the Social Security Act

Section 319(d) of the bill adds a new subsection (v) to section 202 of the Social Security Act. If an individual is granted a tax exemption under section 1402(h) of the Internal Revenue Code of 1954, no benefits or other payments are to be payable to him under title II of the Social Security Act, no payments are to be made on his behalf under part A of title XVIII (hospital insurance benefits for the aged), and no benefits or other payments are to be payable to him on the basis of the wages and self-employment income of any other person, after the filing of his waiver of benefits pursuant to section 1402(h) of the code. If the tax exemption ceases to be applicable, the waiver is to cease to be applicable to the extent benefits or other payments are based (1) on his self-employment income for and after the first taxable year for which the waiver ceases to be effective, and (2) on his wages for and after the calendar year which begins with or in such taxable year.

Effective date

Section 319(e) of the bill provides that the amendments made by section 319 will apply with respect to taxable years beginning after December 31, 1950. Section 319(e) of the bill also provides, for purposes of such effective date, that chapter 2 of the Internal Revenue Code of 1954 (secs. 1401 through 1403) shall be treated as applying to all taxable years beginning after December 31, 1950. Thus, an application for exemption from tax under section 1402(h) of the Internal Revenue Code of 1954 will be treated as an application for exemption from the tax on self-employment income imposed by the Internal Revenue Code of 1939.

Refund or credit of taxes

Section 319(f) of the bill provides that if refund or credit of any overpayment resulting from the enactment of such section 319 is prevented, by the operation of any law or rule of law, on the date of enactment of the bill or at any time on or before April 15, 1966, refund

or credit of such overpayment may, nevertheless, be made or allowed if claim therefor is filed on or before April 15, 1966. Section 319(f) further provides that no interest is to be allowed or paid on any overpayment resulting from the enactment of section 319.

SECTION 320. INCREASE IN EARNINGS COUNTED FOR BENEFIT AND TAX PURPOSES

Section 320 of the bill raises the maximum amount of annual earnings subject to social security tax and counted toward benefits (the contribution and benefit base) from \$4,800 to \$5,600 for the years 1966 through 1970, and from \$5,600 to \$6,600 beginning with 1971.

Amendments to Title II of the Social Security Act

Definition of wages

Section 320(a)(1) of the bill amends section 209(a) of the Social Security Act (defining wages) to make the \$5,600 contribution and benefit base applicable to wages paid after 1965 and before 1971 and to make the \$6,600 base applicable to wages paid after 1970.

Definition of self-employment income

Section 320(a)(2) amends section 211(b)(1) of the act (defining self-employment income) to make the \$5,600 contribution and benefit base applicable for taxable years ending after 1965 and before 1971 and to make the \$6,600 base applicable for taxable years ending after 1970.

Quarter of coverage

Section 320(a)(3) amends clauses (ii) and (iii) of section 213(a)(2) of the act (defining quarter of coverage) to provide that an individual will be credited with a quarter of coverage for each quarter of a calendar year after 1965 and before 1971 if his wages for such year equal \$5,600 (rather than \$4,800 as in present law) and with a quarter of coverage for each quarter of a calendar year after 1970 if his wages for such year equal \$6,600. An individual will also be credited with a quarter of coverage for each quarter of a taxable year ending after 1965 and before 1971 in which the sum of his wages and self-employment income equals \$5,600 (rather than \$4,800) and for each quarter of a taxable year ending after 1970 in which the sum of his wages and self-employment income equals \$6,600.

Average monthly wage

Section 320(a)(4) amends section 215(e)(1) of the act (relating to the amount of annual earnings that can be counted in computing an individual's average monthly wage) so as to increase from \$4,800 to \$5,600, effective for calendar years after 1965 and before 1971, and from \$5,600 to \$6,600, effective for calendar years after 1970, the maximum amount of annual earnings that may be counted in the computation of an individual's average monthly wage for purposes of determining benefit amounts.

*Amendments to the Internal Revenue Code of 1954**Definition of self-employment income*

Section 320(b)(1) of the bill amends section 1402(b)(1) of the Internal Revenue Code of 1954 (defining self-employment income) by increasing the maximum annual limitation on self-employment income subject to the self-employment tax from \$4,800 to \$5,600 for taxable years ending after 1965 and before 1971, and from \$5,600 to \$6,600 for taxable years ending after 1970.

Definition of wages

Section 320(b)(2) amends section 3121(a)(1) of the code (defining wages) by increasing the maximum annual limitation on wages subject to social security tax from \$4,800 to \$5,600 for calendar years after 1965 and before 1971, and from \$5,600 to \$6,600 for calendar years after 1970.

Federal service

Section 320(b)(3) amends section 3122 of the code (relating to Federal service) so as to conform its provisions to the changes made in increasing the contribution and benefit base from \$4,800 to \$5,600 for calendar years after 1965 and before 1971, and to \$6,600 for calendar years after 1970.

Returns in the case of governmental employees in Guam and American Samoa

Section 320(b)(4) amends section 3125 of the code (relating to governmental employees in Guam and American Samoa) so as to conform its provisions to the \$5,600 contribution and benefit base for calendar years after 1965 and before 1971, and to the \$6,600 base for calendar years after 1970. (These increases in the base will also apply to the temporary employees of the District of Columbia who are included in section 3125 by section 317(c) of the bill.)

Special refunds of employee tax

Sections 320(b)(5) and 320(b)(6) amend section 6413(c) of the code (relating to special refunds of social security tax paid by an employee on aggregate wages in excess of \$4,800 received by him from more than one employer during a calendar year) so as to conform the special refund provisions to the \$5,600 contribution and benefit base for calendar years after 1965 and before 1971, and to the \$6,600 base for calendar years after 1970.

Effective Date

Section 320(c) provides effective dates for the changes made by the section. The amendments made by section 320 (a)(1) and (a)(3)(A) and by section 320(b) (except par. (1)) are applicable only with respect to remuneration paid after December 1965; the amendments made by section 320 (a)(2), (a)(3)(B), and (b)(1) are applicable only with respect to taxable years ending after 1965; and the amendments made by section 320(a)(4) are applicable only with respect to calendar years after 1965.

SECTION 321. CHANGES IN TAX SCHEDULES

Section 321 of the bill provides new schedules of social security tax rates, with the rates provided for hospital insurance being set forth in schedules which are separate from those provided for old-age, survivors, and disability insurance.

Self-employment tax

Section 321(a) of the bill amends section 1401 of the Internal Revenue Code of 1954 to provide new schedules of social security tax rates on self-employment income.

Subsection (a) of the amended section 1401 provides a schedule of tax rates on self-employment income for old-age, survivors, and disability insurance. Under present law the rates of self-employment tax for old-age, survivors, and disability insurance are as follows:

Taxable years beginning after—	Tax rate (percent)
1962 (and before 1966)	5.4
1965 (and before 1968)	6.2
1967	6.9

Under the bill, the rates of self-employment tax for old-age, survivors, and disability insurance will be as follows:

Taxable years beginning after—	Tax rate (percent)
1965 (and before 1969)	6.0
1968 (and before 1973)	6.6
1972	7.0

Subsection (b) of the amended section 1401 provides a schedule of tax rates on self-employment income for hospital insurance. The rates of self-employment tax provided for hospital insurance are as follows:

Taxable years beginning after—	Tax rate (percent)
1965 (and before 1967)	0.35
1966 (and before 1973) .....	.50
1972 (and before 1976) .....	.55
1975 (and before 1980) .....	.60
1979 (and before 1987) .....	.70
1986 .....	.80

The new section 1401(b) provides that, for purposes of the tax imposed in respect of hospital insurance, the exclusion of employee representatives by section 1402(c)(3) of the code will not apply. Thus, the performance of service by an individual as an employee representative, as defined in section 3231(c) of the code (the Railroad Retirement Tax Act), is included in the term "trade or business" as defined in section 1402(c) for purposes of the tax imposed by the new section 1401(b).

Taxes on employees and employers

Section 321(b) and 321(c) of the bill amend section 3101 and section 3111, respectively, of the Internal Revenue Code of 1954 to provide new schedules of social security tax rates on wages for both employees and employers.

Subsection (a) of the amended section 3101 and subsection (a) of the amended section 3111 provide schedules of tax rates on wages

for old-age, survivors, and disability insurance. Under present law the tax rates for employees and employers are as follows:

Calendar years—	Tax rate employer and employee, each (percent)
1963-65, inclusive.....	3 $\frac{5}{8}$
1966-67, inclusive.....	4 $\frac{1}{8}$
1968 and after.....	4 $\frac{5}{8}$

Under the bill, the rates for employees and employers for old-age, survivors, and disability insurance will be as follows:

Calendar years—	Tax rate employer and employee, each (percent)
1966-68, inclusive.....	4.0
1969-72, inclusive.....	4.4
1973 and after.....	4.8

Subsection (b) of the amended section 3101 and subsection (b) of the amended section 3111 provide schedules of tax rates on wages for hospital insurance. The employee and employer tax rates for hospital insurance are as follows:

Calendar years—	Tax rate employer and employee, each (percent)
1966.....	0.35
1967-72, inclusive.....	.50
1973-75, inclusive.....	.55
1976-79, inclusive.....	.60
1980-86, inclusive.....	.70
1987 and after.....	.80

For purposes of the employee tax and the employer tax imposed by the new sections 3101(b) and 3111(b), respectively, the exception from employment contained in paragraph (9) of section 3121(b) of the code is made inapplicable. Thus service performed by an employee as defined in section 3231(b) of the code (the Railroad Retirement Tax Act) constitutes employment, unless excluded under some paragraph (other than paragraph (9)) of section 3121(b), for purposes of determining wages subject to the employee and employer taxes imposed by the new sections 3101(b) and 3111(b).

Effective dates

Section 321(d) of the bill provides that the amendments made by section 321(a) will apply only with respect to taxable years which begin after December 31, 1965, and that the amendments made by sections 321(b) and 321(c) will apply with respect to remuneration paid after December 31, 1965.

SECTION 322. REIMBURSEMENT OF TRUST FUNDS FOR COST OF NONCONTRIBUTORY MILITARY SERVICE CREDITS

Section 322 of the bill amends section 217(g) of the Social Security Act to revise the provisions for the reimbursement of the trust funds for the cost of benefits based on military service in the period from September 16, 1940, through December 1956.

Paragraph (1) of the revised section 217(g) provides that in September 1965 and in every fifth September thereafter up to and in-

cluding September 2010, the Secretary of Health, Education, and Welfare will determine the amount which, if paid in equal annual installments, would be needed to place the old-age and survivors insurance, disability insurance, and hospital insurance trust funds in the same position at the end of June 2015 as they would be if benefits based on military service in the period from September 16, 1940, through December 1956 had not been provided.

Paragraph (2) of the revised section 217(g) authorizes annual appropriations to each of the trust funds in the amounts determined under paragraph (1) for each fiscal year in the 50 fiscal years, 1966–2015, as reimbursement for the costs of paying benefits based on military service in the period from September 16, 1940, through December 1956.

Paragraph (3) of the revised section 217(g) authorizes a final appropriation to each of the trust funds for the fiscal year ending June 30, 2016, to place the trust funds in the same position in which they would have been on June 30, 2015, if benefits based on military service in the period from September 16, 1940, through December 1956 had not been provided.

Paragraph (4) of the revised section 217(g) provides for annual appropriations to the old-age and survivors insurance, disability insurance, and hospital insurance trust funds to meet the costs of paying benefits after June 30, 2015, based on military service in the period from September 16, 1940, through December 1956.

SECTION 323. ADOPTION OF CHILD BY RETIRED WORKER

Section 323(a) of the bill amends section 202(d) of the Social Security Act (relating to child's insurance benefits) by striking out the last sentence in paragraph (1) (relating to adoptions by disabled workers) and by adding two new paragraphs (9) and (10). The new paragraph (9) of section 202(d) in effect retains the existing provisions relating to adoptions by disabled workers and makes such provisions applicable in the case where the worker is entitled to old-age insurance benefits and was entitled to disability insurance benefits for the month preceding the first month for which he was entitled to old-age insurance benefits. The effect of the new paragraph (10) of section 202(d) is to restrict the payment of child's insurance benefits when a child is adopted by a worker after the worker became entitled to old-age insurance benefits (without first becoming entitled to disability insurance benefits) by adding the following new requirements: (1) the child must have been living with the worker at the time the worker became entitled to old-age insurance benefits or adoption proceedings had begun at or before that time; (2) the child must have been receiving at least one-half of his support from the worker for the entire year before the worker became entitled to old-age insurance benefits or before a period of disability began which continued until he became entitled to old-age insurance benefits; and (3) the adoption must have been completed within 2 years after the worker became entitled to old-age insurance benefits.

Section 323(b) of the bill provides that the new requirements (added by sec. 323(a)) will be effective with respect to applications for child's insurance benefits on or after the date of enactment of the bill. The requirement that adoption be completed within 2 years after the

worker became entitled to benefits is not to apply in any case where a child is adopted within 1 year after the month in which the bill is enacted.

SECTION 324. EXTENSION OF PERIOD FOR FILING PROOF OF SUPPORT AND APPLICATIONS FOR LUMP-SUM DEATH PAYMENT

Section 324(a) of the bill amends section 202(p) of the Social Security Act. The amended section 202(p) provides that in any case where the proof of support required in connection with an application for husband's insurance benefits, widower's insurance benefits, or parent's insurance benefits, or the application for a lump-sum death payment, is not filed within the 2-year period prescribed in the applicable sections of the law and where there was good cause for failure to file such proof or application, the application or proof may be filed at any time after the expiration of the 2-year period and will be deemed to have been filed within that period. Under existing law an extension of only 2 additional years is provided in such cases.

Section 324(b) of the bill provides that the amendment made by subsection (a) will be effective with respect to monthly benefits and lump-sum death payments based on applications filed in or after the month of enactment of the bill.

SECTION 325. TREATMENT OF CERTAIN ROYALTIES FOR RETIREMENT TEST PURPOSES

Section 325(a) of the bill amends section 203(f)(5) of the Social Security Act, relating to the determination of a person's net earnings and net loss from self-employment for retirement test purposes, by adding a new subparagraph (D). The new subparagraph provides that, in determining the net earnings from self-employment of a beneficiary who has attained age 65, there is to be excluded in computing his gross income from a trade or business any royalties received in or after the year in which he attained age 65 if he shows to the satisfaction of the Secretary of Health, Education, and Welfare that the royalties are attributable to a copyright or patent which was obtained before the taxable year in which he attained age 65 and that the property to which the copyright or patent relates was created by his own personal efforts.

Section 324(b) of the bill provides that the changes made by subsection (a) will be effective for taxable years beginning after 1964.

SECTION 326. AMENDMENTS PRESERVING RELATIONSHIP BETWEEN RAILROAD RETIREMENT AND OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE SYSTEMS

Section 326(a) of the bill makes a technical amendment to section 1(q) of the Railroad Retirement Act of 1937 to preserve the existing relationship between such act and title II of the Social Security Act. Under this amendment, references to the Social Security Act in the Railroad Retirement Act of 1937 will be considered to be references to the Social Security Act as amended in 1965.

Section 326(b) of the bill amends section 5(l)(9) of the Railroad Retirement Act of 1937, relating to situations where social security credits are transferred to the railroad retirement program. Benefits to survivors of a railroad employee are payable either under the railroad retirement program or the social security program, but not both, on the basis of the employee's combined earnings under both programs. In general, benefits are payable under the railroad retirement program if the individual has a current connection with the railroad industry at the time of his death. The compensation for railroad service is creditable up to \$5,400 a year for this purpose. However, under present law, where an individual has less than the maximum of \$5,400 in creditable compensation for a year, only enough of his wages from employment subject to title II of the Social Security Act can be added to his compensation to increase the combined creditable earnings to \$4,800, the present limit on wages for a year under title II of the Social Security Act. To take into account the increases made by section 320 of the bill in the maximum amount of annual earnings creditable under social security, section 326(b) of the bill amends section 5(l)(9) of the Railroad Retirement Act of 1937 to permit the crediting of wages for a year in such an amount as to cause the combined total earnings to be as much as the new earnings and tax base under social security—\$5,600 a year for the years 1966 through 1970, and \$6,600 a year for years after 1970.

SECTION 327. TECHNICAL AMENDMENT RELATING TO MEETINGS OF BOARD OF TRUSTEES OF THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE TRUST FUNDS

Section 327 of the bill amends section 201(c) of the Social Security Act to require the Board of Trustees of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund to meet at least once each calendar year, rather than once each 6 months as required under present law. (A similar provision for annual meetings of the Board of Trustees is included in the provisions of the bill (discussed above) creating the Federal Hospital Insurance Trust Fund and the Federal Supplementary Health Insurance Benefits Trust Fund.)

TITLE IV—PUBLIC ASSISTANCE AMENDMENTS

SECTION 401. INCREASED FEDERAL PAYMENTS UNDER PUBLIC ASSISTANCE TITLES OF THE SOCIAL SECURITY ACT

Section 401(a) of the bill amends section 3(a)(1) of the Social Security Act. The first step of the formula by which Federal payments to States with approved plans for old-age assistance under title I are determined is changed so as to provide Federal sharing in 31/37ths of the first \$37 of the average monthly assistance payment instead of 29/35ths of the first \$35 of the average monthly assistance payment. The amendment also has the effect of applying the Federal percentage in the second step of the present formula to an additional \$38, instead

of the present additional \$35, of the State's average payment. The additional Federal share in State expenditures for medical care, determined on the basis of the Federal medical percentage of the next \$15 of a State's average payment, available under the third step of the present formula, is continued, thus giving under the formula as changed by the bill a potential Federal participation in State expenditures up to an average of \$90. In addition, the formula is restated for the second and third steps, so as to give recognition to the State's expenditures for medical care before applying the Federal percentage to the remaining expenditures for which Federal participation is available. The formula, as restated by section 401 (a) of the bill, would pay States, in addition to the amount computed under section 3(a) (1) (A) of the Social Security Act, and in lieu of the amounts now computed under section 3(a)(1) (B) and (C) of such act, the larger of the following:

(i) (I) the Federal percentage (as defined in sec. 1101(a)(8)) of all expenditures for old-age assistance in excess of expenditures counted under clause (A), but not counting so much of the excess as exceeds \$38 times the total number of recipients of old-age assistance; plus

(II) 15 percent of the State's expenditures in the form of medical care, up to a maximum of \$15 times the total number of recipients of old-age assistance; or

(ii) (I) the Federal medical percentage (as defined in sec. 6(c)) of all expenditures in excess of expenditures counted under clause (A), but not counting expenditures that exceed (a) \$52 times the total number of recipients, or (b) if smaller, the total expenditures for medical care plus \$37 times the total number of recipients; plus

(II) the Federal percentage of all expenditures in excess of expenditures counted under clause (A) and the provisions of clause (B)(ii) described in these paragraphs (ii) (I) and (II), but not counting so much of the excess as exceeds \$38 times the total number of recipients.

Section 401(b) of the bill makes corresponding changes in title XVI of the Social Security Act.

Section 401(c) of the bill amends section 403(a)(1) of the Social Security Act so as to change the formula by which the Federal share of aid to families with dependent children is determined. The present share of 14/17ths of the first \$17 of the average monthly assistance payment is increased to 5/6ths of the first \$18 of such payment. The ceiling for Federal participation is raised from \$30 a month to \$32 a month per recipient.

Sections 401(d) and 401(e) of the bill amend sections 1003(a)(1) and 1403(a)(1), respectively, of the Social Security Act so as to change the formula by which the Federal share of aid to the blind or aid to the permanently and totally disabled is determined. The present share of 29/35ths of the first \$35 of the average monthly assistance payment is increased to 31/37ths of the first \$37 of such payment, and the ceiling for Federal participation is raised from \$70 a month to \$75 a month per recipient.

Section 401(f) of the bill provides that the amendments made by the preceding provisions of section 401 will apply to expenditures

made after December 31, 1965, under a State plan approved under title I, IV, X, XIV, or XVI of the act.

SECTION 402. PROTECTIVE PAYMENTS

Sections 402(a) and 402(b) of the bill amend sections 6(a) and 1605(a), respectively, of the Social Security Act (as such sections are amended by section 221 of the bill), to extend the definitions of "old-age assistance" and "aid to the aged, blind, or disabled" to include protective payments—i.e., payments made on behalf of the recipient to an individual who (as determined in accordance with standards prescribed by the Secretary) is interested in or concerned with the welfare of the recipient. The State plan under which the payments are made must include provision for—

- (1) determination by the State agency that protective payments are necessary because, by reason of a physical or mental condition, the recipient is so unable to manage funds that payments to him would be contrary to his welfare;

- (2) making payments in this form only when they (together with other income and resources) will meet all the needs of the individuals with respect to whom they are made, under rules otherwise applicable under the State plan for determining need and the amount of aid or assistance paid;

- (3) special efforts to protect the welfare of the recipient and to improve, to the extent possible, his capacity for self-care and ability to manage funds;

- (4) periodic review by the State agency to determine whether payments in this form are still necessary, with provision for termination of such payments if not necessary and for seeking judicial appointment of a guardian or legal representative when such action will best serve the interests of the recipient; and

- (5) opportunity for a fair hearing before the State agency on the determination that protective payments are necessary.

Section 402(c) of the bill provides that the amendments made by the preceding provisions of section 402 will apply to expenditures made after December 31, 1965, under a State plan approved under title I or XVI of the act.

SECTION 403. DISREGARDING CERTAIN EARNINGS IN DETERMINING NEED UNDER ASSISTANCE PROGRAMS FOR THE AGED

Section 403 of the bill amends sections 2(a)(10)(A) and 1602(a)(14) of the Social Security Act, effective January 1, 1966. These sections of the Social Security Act allow the States in determining need for old-age assistance or for aid to the aged, blind, or disabled (insofar as it relates to the aged) to disregard, of the first \$50 per month of earned income, not more than the first \$10 thereof plus one-half of the remainder. Under the amendments made by the bill, these amounts would be increased to \$80 and \$20, respectively; thus, in determining need for such assistance or aid, the State agency may disregard, of the first \$80 of earned income for any month, not more than the first \$20 thereof plus one-half of the remainder.

SECTION 404. ADMINISTRATIVE AND JUDICIAL REVIEW OF PUBLIC ASSISTANCE DETERMINATIONS

Section 404 of the bill amends title XI of the Social Security Act by adding a new section 1116 designed to provide for administrative and judicial review of certain administrative determinations made after December 31, 1965, with respect to State plans under the public assistance titles of such act (including the new title XIX added by sec. 121 of the bill).

Under the new section 1116(a)(1), the Secretary of Health, Education, and Welfare must, not later than 90 days after a State submits a plan to him for approval under one of the public assistance titles, make a determination as to whether it fulfills the conditions for approval specified in such title. Such 90-day period may be extended by written agreement of the Secretary and such State.

Section 1116(a)(2) provides that a State which is dissatisfied with such a determination may, within 60 days of notification thereof, petition the Secretary to reconsider his determination of disapproval. The Secretary must thereupon schedule a hearing and notify the State of the time and place. The hearing must be held not less than 20 days nor more than 60 days after the date the State is given notice thereof, unless the Secretary and the State agree in writing to another time. The decision of the Secretary to affirm, modify, or reverse his original determination must be made within 60 days after the hearing is concluded.

Section 1116(a)(3) provides that a State which is dissatisfied with a final determination by the Secretary on such a reconsideration or with his final determination (to withhold funds) under section 4, 404, 1004, 1404, or 1604 of the Social Security Act, or under section 1904 of such act (as added by section 121(a) of the bill), may, within 60 days of notification thereof, petition the United States court of appeals for the circuit in which the State is located to review such determination. The clerk of such court will forthwith transmit a copy of the petition to the Secretary, who will thereupon file in the court the record of the administrative proceedings as provided in 28 U.S.C. 2112.

Section 1116(a)(4) makes the Secretary's findings of fact conclusive unless they are substantially contrary to the weight of the evidence. The court is authorized, for good cause shown, to remand the case to the Secretary to take further evidence. In such case, the Secretary may make new or modified findings of fact and may modify his previous action, and he will certify to the court the record of such additional proceedings. Such findings of fact will likewise be conclusive unless substantially contrary to the weight of evidence.

Section 1116(a)(5) vests jurisdiction in the court to affirm the Secretary's action or to set it aside, in whole or in part. The judgment is reviewable by the Supreme Court upon certiorari or certification as provided in 28 U.S.C. 1254.

Section 1116(b) provides that, for purposes of obtaining the administrative and judicial reviews authorized under the new section 1116(a), any amendment of an approved State plan may, at the State's option, be treated as the submission of a new State plan.

Section 1116(c) provides that action pursuant to an initial determination of the Secretary described in section 1116(a) is not to be stayed pending reconsideration. In the event, however, that the

Secretary subsequently determines that such initial determination was incorrect, the funds incorrectly withheld or otherwise denied must be restored to the State forthwith in a lump sum.

Section 1116(d) provides that the State is entitled to and upon request must receive reconsideration of any determination by the Secretary to disallow Federal financial participation in any item or class of items for which the State claimed such participation under a public assistance title of the Social Security Act (including the new title XIX, added by the bill).

SECTION 405. MAINTENANCE OF STATE PUBLIC ASSISTANCE EXPENDITURES

Section 405 of the bill amends title XI of the Social Security Act by adding a new section 1117 designed to assure the maintenance of State effort in the financing of approved State plans under the public assistance titles of such act.

The new section 1117(a) provides that any increase in the Federal payments to a State for any quarter in the period January 1, 1966, through June 30, 1969—i.e., the increase in the total of the amounts otherwise payable for such quarter pursuant to determinations made under sections 3, 403, 1003, 1403, and 1603 of such act and under section 1903 of such act (as added by section 121(a) of the bill)—will be reduced to the extent that the State has not maintained expenditures from State and local funds of at least the same amount as was spent under its approved plans in a base period against which current quarter expenditures would be measured.

The amount of the reduction, if any, for a current quarter would be the amount by which—

(1) the excess of (A) the total of the Federal shares determined for the State under all of the sections of the act referred to above for such quarter over (B) the total of the Federal shares determined under sections 3, 403, 1003, 1403, and 1603 of the Act for the same quarter of fiscal year 1965, is greater than

(2) the excess of (A) the total expenditures for the current quarter under all of the State's approved plans (including its plan under the new title XIX) over (B) the total of the expenditures under all of its plans under titles I, IV, X, XIV, and XVI for the same quarter of fiscal year 1965.

The new section 1117(a) also gives the State the option to substitute (with respect to each of the quarters of any fiscal year) for the amount determined under paragraph (1)(B) above—

(3) the total of the Federal shares determined for the State for the same quarter in fiscal year 1964; or

(4) the average of the totals determined for each quarter in fiscal year 1964 or fiscal year 1965.

If the State elects the substitution under paragraph (3), there will be substituted for the amount determined under paragraph (2)(B) the total expenditures under its plans approved under titles I, IV, X, XIV, and XVI for the quarter referred to in paragraph (3). If the State elects the substitution under paragraph (4) for either of the years referred to therein, there will be substituted for the amount determined under paragraph (2)(B) the average of the total expenditures under such approved plans for each quarter in the same fiscal year.

Where the State has elected to substitute under paragraph (3) or (4), that election will apply with respect to all quarters in the fiscal year for which the substitution (under paragraph (3) or (4), as the case may be) has been elected.

The new section 1117(b) provides that expenditures under any or all plans of a State approved under title I, IV, X, XIV, XVI, or XIX (as added by the bill), and the reduction determined with respect thereto under such section 1117, will be determined on the basis of data in the quarterly reports of the State to the Secretary pursuant to and in accordance with his requirements under such titles; and determinations so made will be conclusive for purposes of such new section.

The new section 1117(c) provides that if a reduction is required under section 1117 (a) and (b) in the total of the Federal shares determined for a State under sections 3, 403, 1003, 1403, 1603, and 1903 (as added by the bill) for any quarter, the Secretary is to determine which of such amounts should be reduced and the extent thereof in such way as he deems will best further the purpose of maintaining State effort under the State's federally aided public assistance programs, and with the total of such reductions equalling the reduction required under section 1117 (a) and (b).

SECTION 406. DISREGARDING OASDI BENEFIT INCREASE, AND CHILD'S INSURANCE BENEFIT PAYMENTS BE- YOND AGE 18, TO THE EXTENT ATTRIBUTABLE TO RETROACTIVE EFFECTIVE DATE

Section 406 of the bill permits a State, notwithstanding the requirements in titles I, IV, X, XIV, and XVI of the Social Security Act for the consideration of income and resources in determining need for aid or assistance under a plan of the State approved under any such title, to disregard the amount of any OASDI monthly insurance payment to a beneficiary which is attributable to months before the month he receives such payment, but only to the extent it is also attributable (1) to the increase in such insurance benefits resulting from the enactment of section 301 of the bill, or (2) to the payment of child's insurance benefits after attainment of age 18, in the case of children attending school, resulting from the enactment of section 306 of the bill.

SECTION 407. EXTENSION OF GRACE PERIOD FOR DIS- REGARDING CERTAIN INCOME FOR STATES WHERE LEGISLATURE HAS NOT MET IN REGULAR SESSION

Section 407 of the bill provides that, notwithstanding section 701 of the Economic Opportunity Act of 1964 (enacted August 20, 1964), funds to which a State is otherwise entitled under the public assistance titles of the Social Security Act (including title XIX as added by the bill) for any period before the first month following the month of adjournment of the State's first regular legislative session adjourning after August 20, 1964, will not be withheld because of action taken pursuant to a statute of the State which prevents the State from complying with the requirements of section 701(a) of the Economic

Opportunity Act of 1964 (relating to the disregard of certain income in determining need for federally aided public assistance).

SECTION 408. TECHNICAL AMENDMENTS TO ELIMINATE
PUBLIC ASSISTANCE PROVISIONS WHICH BECOME
OBSOLETE IN 1967

Section 407 of the bill makes a series of technical amendments to provisions of the Social Security Act (and to section 618 of the Revenue Act of 1951). With one exception, such amendments become effective July 1, 1967. Such amendments would eliminate various provisions in present law made obsolete by the enactment of section 121(b) of the bill. Under such section 121(b), for any period after June 30, 1967, Federal financial participation in vendor medical care payments for needy individuals will no longer be available to any State under titles I, IV, X, XIV, or XVI of the Social Security Act, and can only be provided with respect to State plans approved under the new title XIX of such act (as added by sec. 121(a) of the bill); similarly, for any period after June 30, 1967, Federal financial participation in medical assistance for the aged will no longer be available under title I or XVI and can only be provided with respect to State plans approved under the new title XIX.

Section 408(i)(1) of the bill changes the limitation in section 1108 of the Social Security Act on payments to Puerto Rico, the Virgin Islands, and Guam. Under section 408(i)(2) of the bill, these changes are effective for fiscal years beginning on or after the date on which the plan of any such jurisdiction under title XIX of such Act (as added by the bill) is approved, or beginning on or after July 1, 1967, whichever is earlier.

V. SEPARATE VIEWS OF THE REPUBLICANS ON H.R. 6675

GENERAL STATEMENT

The Republican members of the committee are unanimous in their opposition to the provisions of this bill providing for hospitalization for the aged financed through the social security tax system. For the most part, we support and favor the other amendments to the social security laws as contained in the bill, many of which were proposed by Republicans.

We also fully support the concept that adequate health insurance should be made available to the aged at a reasonable cost. Such a program, however, should be voluntary. It should reflect ability to pay. Participation on the part of the Government should be financed out of the general revenues, and not by a regressive payroll tax upon a segment of the population, many of whom may be least able to pay for health insurance for others.

We offer a substitute program of health insurance (H.R. 4351) more comprehensive in benefits than the combined program proposed in parts 1 and 2 of title I of the committee bill. Our proposal has broad Republican sponsorship (H.R. 4351, H.R. 4352, H.R. 4353, H.R. 4354, H.R. 4355, H.R. 4356, H.R. 4357, H.R. 4358, H.R. 4519, H.R. 5022, H.R. 5031, H.R. 5582, H.R. 6690). It is predicated upon the voluntary enrollment concept, a principle which the majority recognizes in the medical services program which was added to the administration's original "medicare" bill during the closing days of the committee's deliberations. If the enrollment principle is sound for the supplemental program in the committee bill, it should be applied across the board under a uniform comprehensive health insurance program such as that offered in the Republican bills. Not only are the benefits more extensive, but it also provides protection for catastrophic illness. The Republican program is described elsewhere in this report.

REPUBLICAN OPPOSITION TO HOSPITALIZATION BENEFITS UNDER SOCIAL SECURITY

PRELIMINARY STATEMENT

In opposing hospitalization for the aged under social security, the Republican members of the committee are not unmindful of the increased cost of private health insurance for those over age 65. We believe that the reliance on a payroll tax to finance a hospitalization program jeopardizes the cash benefit program under the social security system by imposing upon that system a liability to finance undetermined future service benefits. The magnitude of that liability should cause concern to anyone dedicated to the preservation of social security cash benefits.

The committee bill would impose upon today's workers a liability of approximately \$35 billion for hospitalization benefits solely for those already over age 65.¹ This blanket extension of benefits to those

¹ An additional \$3.3 billion will be financed out of general revenues, making a total of \$38.3 billion as the cost of the hospital benefit program for those already now age 65.

over age 65 could only be justified on the basis that all of the aged are in dire need while all of those who will be required to pay the additional payroll taxes have ample means. This is a wholly unrealistic assumption. The shifting of a \$35 billion liability from those presently retired to the active work force cannot be reconciled on the basis of "ability to pay."

The hospitalization program proposed in this bill, as the majority now admits, was "oversold." In an effort to avoid the disillusionment and dissatisfaction which was bound to result from the general misunderstanding with respect to the benefits in the administration's program, the committee added a supplemental voluntary insurance program.

There is an equal, or even greater, lack of understanding with respect to the taxes which may ultimately be required to finance these obligations. The so-called medicare program has been widely advanced as providing *prepaid* medical care for the aged, *at a cost of only a few cents per week*. This is equally misleading.

Benefits financed through a payroll tax carries the erroneous implication of "entitlement." The recipients have been led to believe that these benefits become a matter of right. Both cash benefits and hospital benefits under the social security program will be continued only so long as the active worker is willing to pay the taxes required to finance those benefits. By the admission of the former Secretary of Health, Education, and Welfare before the last Congress, the combined payroll tax in the committee bill exceeds the limits of an acceptable payroll tax.

Recognizing this, the committee bill makes an obvious effort "to soften the blow" on the work force. At the outset the hospital benefits will be financed with only a fraction of the ultimate tax that must be assessed to finance the benefits. Notwithstanding the increases in cash benefits, the regular social security tax rate provided in the bill for 1966 is less than the rate called for in existing law. The taxes which will be paid on account of today's younger worker are not commensurate with the benefits provided for him at age 65. When he understands this, will the worker be willing to pay the tax? If not, both cash benefits and hospital benefits will be in jeopardy.

COMMITTEE BILL COSTS MORE FOR LESS PROTECTION THAN REPUBLICAN PROPOSAL

The majority has finally recognized, as the Republicans long contended, that the limited hospitalization benefits provided for under the administration's original bill (H.R. 1)—widely advertised as "medicare"—were woefully inadequate. In an effort to meet this criticism, the Democrats borrowed from the Republican proposal and added a voluntary program of insurance for medical services. The committee bill now provides for a mandatory hospitalization program financed by a payroll or social security tax, together with a voluntary program for medical services financed partially by contributions and partially out of the general revenues of the Treasury. Notwithstanding diverse means of enrollment and financing, the package of benefits offered under the dual approach proposed in the committee bill still does not fully meet the needs of the aged.

While the adoption of the voluntary medical insurance program partially remedies the inadequacy of the administration's original

"medicare" bill, the committee bill still fails to cover two of the basic concerns of the aged; namely (1) the high and recurrent cost of drugs, and (2) the ever-present risk of a catastrophic illness. Both were covered in the substitute proposal offered by the Republicans.

On the other hand, the cost to the taxpayer—whether he pays a payroll tax or an income tax—of the comprehensive health insurance offered by the Republicans, is less than the cost of the administration's original hospital program. In preparing its estimates, the Department of Health, Education, and Welfare has assumed 80 percent participation in the voluntary medical insurance program in H.R. 6675. On the same assumption, the relative cost of the Republican proposal would be \$400 million less than the cost of the administration's hospital benefits program alone.

Comparative cost of H.R. 6675 and Republican proposal based on 80 percent participation

[In billions]

	H.R. 6675	Republican proposal
Hospital benefit.....	\$2.30	.....
Medical benefit.....	1.12	.....
Total, cost of program.....	3.42	\$2.90
Less: Premium contributions.....	.56	1.00
To be financed by taxpayers.....	2.86	1.90

Source: Department of Health, Education, and Welfare.

While the estimates assume 80 percent participation, the Republicans would hope that the participation might be much greater. In fact, the Chief Actuary for the Department estimated that as many as 95 percent of the aged would participate in the Republican program. Even if we assume 100 percent participation, the net cost to the general revenues would be less than \$2 billion for the first full year of coverage. This results from the fact that as participation increases, there are offsetting reductions in other programs and the tax revenue loss due to the medical deduction of \$1.2 billion presently being claimed by the aged will be practically eliminated.

Net cost of Republican comprehensive health insurance proposal, 100 percent coverage

	Billions
Benefit cost.....	\$3.65
Less:	
Premium contributions.....	1.25
Tax revenue from medical deduction.....	.25
Reduction of Federal cost for OAA-MAA programs.....	.35
Total.....	1.85
Cost to general revenues, net.....	1.80

In addition, the cost to the States for medical assistance to the aged would likewise be reduced, because the health insurance fund would cover a substantial part of such costs.

ELIGIBILITY PROVISIONS HIGHLY DISCRIMINATORY IN PRINCIPLE AND
IN FACT

The hospitalization provisions of the committee bill, which are predicated upon the administration's original medicare proposal (H.R. 1), provide for 60 days of hospital care and related benefits for the aged irrespective of financial need, without any financial contribution from those already over age 65, and without regard to whether the individual may already be adequately protected against such costs. The bill automatically extends these benefits to all of those *presently* over age 65, and to those who attain that age before 1968, without regard to coverage under the social security system, *except that the bill excludes certain Federal civil service employees and their families irrespective of age.* Anyone reaching age 65 after 1967 must have the specified quarters of coverage under the social security system to be eligible for hospital benefits.

The committee bill thus excludes everyone who attains age 65 after 1967 without the required quarters of social security coverage. This means that until we reach that time when everyone qualifies for cash benefits under social security, there will always be those over age 65 who will not qualify for hospitalization benefits. Yet, this same group will qualify to purchase the voluntary insurance plan to cover the other medical services which was added in the committee bill.

The administration's original bill (H.R. 1) would also have excluded *all* Federal employees. The Republicans sought to make the benefits available to *all retired* Federal employees, just as the benefits are made available to all other persons over age 65. The majority rejected this proposal for the stated reason that with enactment of the Federal Employees' Health Benefits Act of 1959, the Federal Government offered adequate health insurance to its employees. However, the majority agreed to limit exclusion to those Federal employees who retire or have retired after the enactment of the 1959 act, *and their spouses.* Some 250,000 presently retired Federal employees and their spouses, and all future retirees, are excluded from the hospital benefit program.

We know of no justification for excluding any Federal employees. With respect to the Federal employee, the Government stands in role of employer, and should be governed accordingly. The majority takes the position that the hospital benefits in the bill should be denied to the retired Federal employee where other insurance is available. The health insurance provided for in the 1959 act costs the retired Federal employee about \$20 per month for a retired couple. On the other hand, the hospitalization benefits in the committee bill are extended without cost to retired employees of the automotive industry, the agricultural industry, the chemical industry, and other groups notwithstanding that their employers have already provided them with complete hospitalization coverage without cost to them. The committee ignores the role of the Federal Government as an "employer" and discriminates against its own employees.

SEPARATION OF HOSPITALIZATION PROGRAM FROM SOCIAL SECURITY
ILLUSORY

The bill purports to establish a separate hospital insurance fund, financed by a payroll tax, apart from the social security system. In

financing benefits for those presently over age 65, however, the bill distinguishes between the aged who are entitled to receive social security cash benefits and the aged who do not qualify for social security cash benefits. For the former, hospital benefits are to be financed by the payroll tax. For the latter, hospital benefits are to be financed out of the general revenues. If the program is, in fact, separate from the social security system, there is no basis for financing differently hospital benefits for the retired already receiving social security cash benefits as against those not entitled to cash benefits. With respect to the hospital benefit program—if it is a program separate and distinct from the social security system—neither group has made any contribution and neither has any prior entitlement to hospital benefits.

Similarly, those reaching age 65 after 1967—ineligible for the hospitalization program because they do not have the requisite social security coverage—are in no different position with respect to the hospital benefit program than are any of those presently over age 65. Yet benefits are denied to those reaching age 65 after 1967 unless they have the requisite social security coverage. Obviously, therefore, the so-called separation of the hospital benefits from the social security system of cash benefits under social security is purely illusory. It ignores the fact that the hospitalization and social security programs are linked together by a common method of financing (the payroll tax), a common wage base to which the tax is applied, and a common test for entitlement to benefits.

HOSPITALIZATION PROGRAM REAL THREAT TO INTEGRITY OF OASDI CASH BENEFITS

Under the committee bill, the hospital benefit program will be an integral part of the social security system. There is a common method of financing, applied to a common wage base, with a common test for entitlement to benefits. The bill has already been acclaimed by the administration as a program of medical care for the aged *under social security*. A real threat to the integrity of the social security cash benefit system is inherent in the committee bill.

The central fact which must be faced on a proposal to provide hospital benefits—a form of service benefit as contrasted to a cash benefit—is that it is impossible to accurately estimate its future cost. As the chairman of the Ways and Means Committee said in a speech as recently as last September: “These difficult-to-predict future costs, *when such a program is identified with the social security system*, could well have highly dangerous ramifications on the social security cash benefit.” [*Italic added.*]

The American people must have confidence in the continued soundness of the social security program. In the past, the basis of this assurance has been the conservative nature of the assumptions upon which the social security system is based. One of these is the so-called level earnings assumption whereby the condition of the system is measured on the basis of the most recent year for which payroll information has been recorded. It is conservative in that it does not anticipate increase in earnings level even though such increases have been the history of the American economy over the long run. This safety factor which is built into the social security system comes into play because of a cash benefit structure which pays back

less, proportionately, to higher income people than to those whose average wages are lower. Thus, if future earnings increase, as they are very likely to do, this "savings" results because more people will have their benefit computed in the less weighted part of the benefit formula.

No similar assumptions can be made with respect to the hospitalization program. In order adequately to finance the hospitalization program it must be assumed either (1) that the tax rate will be continually increased or (2) that the wage base will be continually "updated" in order to provide additional funds to meet the increase in cost of the services. No one can reasonably assure the committee, or this Congress, that the actuarial cost estimates on which the program has been predicated will be realistic or valid a few years from now. Therefore, it would be unrealistic to assume that the tax rate in the bill—up to 1.60 percent on a wage base of \$6,600—will adequately finance the benefits. In fact, our experience with the estimates submitted by the Department of Health, Education, and Welfare over the past 10 years with respect to the various hospital benefit programs conclusively establishes the opposite.

In 1957, the Department of Health, Education, and Welfare made estimates with respect to the cost of the original Forand bill then pending before the committee. Within a short period of time, the Department was forced to concede that those estimates were wholly inadequate. Based upon the facts known to us today, the estimated cost of that bill should have been at least double the amount of the original estimate. A similar bill with reduced benefits was introduced in 1960. Before the committee hearings were concluded on that bill, the Department had conceded that the costs were greatly underestimated. On the basis of what we know today, the Department underestimated the cost of that bill by at least one-third.

In 1963, when the King-Anderson bill (H.R. 1) was first introduced, it called for a tax rate increase of 0.50 percent (0.25 percent each on employer and employee) with a wage base increase to \$5,000. When the committee conducted hearings on this bill in 1964, only 1 year later, the Department had already readjusted its estimates of the cost to increase both the tax rate and the base.

In January 1965, the Department estimated the cost of the hospitalization program in the administration's bill (H.R. 1) as equivalent to a tax of 0.84 percent on a taxable base of \$5,600. Within the past few weeks, the Department has again revised its estimates upward. This escalation in cost estimates and tax rates has continued up until final action by the committee last week. Notwithstanding that benefits have been reduced from those originally proposed in H.R. 1, the committee bill now proposes a tax up to 1.6 percent on a wage base of \$6,600.

Any member of the committee who is prepared to assure the Congress that these latest and most recent estimates of cost can be relied upon is ignoring 10 years of past experience. This is not to reflect upon the integrity of the actuaries who have participated in making the estimates. Uncertainty with respect to the cost of a program of this type is unavoidable.

The Congress would be wise if, in this context, it considered seriously a statement last year of Labor Minister Gilbert Granval who is responsible for France's social security system. He said in a report to President Charles de Gaulle:

"The financial breaking point is near. The solution cannot be found in the framework of the present system." He is quoted as saying that the chief drain on the French social security system has not been the retirement and other benefits but the health insurance system.

FINANCING OF HOSPITAL BENEFITS IS MISLEADING

In the committee bill, provision is made for a payroll tax using the same wage base as the social security system. The rate of tax and the wage base is, however, escalated in subsequent years. The ultimate tax rate of 1.60 percent provided for in the bill to finance the hospital benefits at a \$6,600 wage base will be more than double the initial tax rate of 0.70 percent assessed on a \$5,600 wage base for 1966. This "gimmick" merely postpones the full impact of the cost. It may make the program more "palatable" today, but it does not, in fact, diminish the burden on the active work force—employees, employers, and self-employed alike—who will be called upon to provide hospital benefits for those already over age 65. The real burden is merely shifted to the future.

The Department has estimated the cost of the program on a 25-year basis—the basis used in the committee bill—is the equivalent of a tax of 1.27 percent on a wage base of \$5,600. Instead, the committee bill proposes to start out with a tax of 0.70 percent. This results in underfinancing the program on a level cost basis during the initial 10-year period. It requires subsequent increases in the tax rate and the wage base to a rate of 1.6 percent on a wage base of \$6,600. In adopting this method of financing, we are misleading today's worker into believing that the cost of the hospital benefit is only a few cents per week. If no one paid more than the initial top rate the program would be "broke" in a couple of years.

Comparison of tax rates in H.R. 6675 with tax rate required to finance hospital benefit program on a level cost basis¹

Year	Wage base	Tax rate	Tax	Level cost (on fixed wage base of \$5,600)	Excess or (deficiency)
1966	\$5,600	\$0.70	\$39.20	\$70.12	(\$30.92)
1967	5,600	1.00	56.00	70.12	(14.12)
1968	5,600	1.00	56.00	70.12	(14.12)
1969	5,600	1.00	56.00	70.12	(14.12)
1970	5,600	1.00	56.00	70.12	(14.12)
1971	6,600	1.00	66.00	70.12	(24.12)
1972	6,600	1.00	66.00	70.12	(24.12)
1973	6,600	1.10	72.60	70.12	2.48
1974	6,600	1.10	72.60	70.12	2.48
1975	6,600	1.10	72.60	70.12	2.48
1976	6,600	1.20	79.20	70.12	9.08
1977	6,600	1.20	79.20	70.12	9.08
1978	6,600	1.20	79.20	70.12	9.08
1979	6,600	1.20	79.20	70.12	9.08
1980	6,600	1.40	84.40	70.12	14.28
1981	6,600	1.40	84.40	70.12	14.28
1982	6,600	1.40	84.40	70.12	14.28
1983	6,600	1.40	84.40	70.12	14.28
1984	6,600	1.40	84.40	70.12	14.28
1985	6,600	1.40	84.40	70.12	14.28
1986	6,600	1.40	84.40	70.12	14.28
1987	6,600	1.60	105.60	70.12	35.48
1988	6,600	1.60	105.60	70.12	35.48
1989	6,600	1.60	105.60	70.12	35.48
1990	6,600	1.60	105.60	70.12	35.48
1991	6,600	1.60	105.60	70.12	35.48

¹ Source: Basic data from Department of Health, Education, and Welfare.

The Department estimates \$35 billion as the cost of the hospital program for those now over age 65 alone, who will not have paid 1 cent of the tax to finance these benefits. If we add to this the cost for those approaching age 65, who will have paid only a nominal tax, the total liability will exceed \$133 billion. It is wholly irresponsible and unnecessary to place this burden on the payroll tax, with the representation which has frequently been made by the proponents of medicare that prepaid health insurance can be provided at a cost of only a few cents per week.

HOSPITAL INSURANCE TAX REGRESSIVE—NO MEASURE OF ABILITY TO PAY

A payroll tax is one of the most unfair and regressive taxes in our entire tax system. It applies to the first dollar of earnings. There are no exemptions, no deduction, no exclusions, and no tax credits. No consideration is given to the taxpayer's ability to pay. The president of a large corporation pays the same tax as his worker. The justification for this type of tax rests upon the basic premise of the social security system that the benefits, for which the tax is levied, are wage related. The financing of a hospital service benefit by a payroll tax represents a basic departure from that principle.

A worker earning a \$3,600 wage, with a wife and two children to support, will pay total Federal income and payroll taxes of \$250 for the year 1966. Of this amount, the payroll tax accounts for \$162, with \$18 of that amount applying to the hospitalization program. At the outset, this worker will be paying \$18 per year towards financing hospital benefits for a retired couple without regard to their financial resources. The same retired couple with an income of \$3,600 will pay no income tax, no social security tax, and no hospital insurance tax. They will have two less mouths to feed, and more spendable income, yet the worker will be forced to pay for their hospitalization.

FEDERAL TAX BURDEN OF MARRIED TAXPAYERS UNDER AGE 65 AND OVER AGE 65¹

Under age 65—Husband and wife with 2 children who take the standard deduction and have income of—

Over age 65—Husband and wife 65 or over (assumed to receive \$1,200 retirement income, social security, pensions, interest, dividends, rent) with income of—

\$3,600					\$3,600				
	In- come tax	OASDI	Health Insur- ance	Total tax		In- come	OASDI	Health Insur- ance	Total tax
1967.....	\$88.00	\$144.00	\$18.00	\$250.00	1967.....	0	0	0	0
1976.....	88.00	172.80	21.60	282.40	1976.....	0	0	0	0
1987.....	88.00	172.80	28.80	289.60	1987.....	0	0	0	0
\$4,600					\$4,600				
1967.....	\$234.00	\$184.00	\$23.00	\$441.00	1967.....	\$89.60	0	0	\$89.60
1976.....	234.00	220.80	27.60	482.40	1976.....	89.60	0	0	89.60
1987.....	234.00	220.80	36.80	491.60	1987.....	89.60	0	0	89.60
\$5,600					\$5,600				
1967.....	\$402.00	\$224.00	\$28.00	\$654.00	1967.....	\$224.00	0	0	\$224.00
1976.....	402.00	316.80	39.60	758.40	1976.....	224.00	0	0	224.00
1987.....	402.00	316.80	52.80	781.60	1987.....	224.00	0	0	224.00

¹ Source: Internal Revenue Code.

PREPAYMENT FOR HOSPITAL BENEFITS A MYTH

Under the committee bill, a worker entering the work force at age 21 today will pay a payroll tax for 44 years—matched by the same amount paid on account of his wage by his employer—to finance a benefit for others. The actual cost of the hospitalization program per worker entering the work force at age 21, with interest at 3½ percent per annum, will amount to \$8,590. That is what will be paid on account of the new generation of workers to finance hospital benefits for those already retired. The same amount invested in private health insurance would provide the worker with far more extensive benefits than are provided under the hospital program contained in the bill.

*Hospital insurance cost under H.R. 6675 for workers at selected ages from Jan. 1, 1966, to retirement*¹

HOSPITAL INSURANCE TAX

Age	Employee tax	Employer tax	Combined
21.....	\$2,003	\$2,003	\$4,006
25.....	1,792	1,792	3,584
35.....	1,264	1,264	2,528
45.....	742	742	1,484

HOSPITAL INSURANCE TAX COMPOUNDED WITH INTEREST AT 3½ PERCENT PER ANNUM

21.....	\$4,295	\$4,295	\$8,590
25.....	3,586	3,586	7,172
35.....	2,067	2,067	4,134
45.....	1,025	1,025	2,050

¹ Source: Department of Health, Education, and Welfare.

The so-called prepayment concept of the committee bill is a myth. The funding of the hospital benefit program is so meager as to be meaningless. When the 21-year-old worker reaches age 65, there will not be \$8,590 in the fund to finance his hospital benefits. The money will have been used to pay benefits for those who preceded him. *It is not contemplated that the amount "prepaid," or set aside in the hospital insurance fund to pay future costs, will exceed the cost of 1 year's benefits.*

Estimated progress of hospital insurance trust fund¹

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Interest on fund	Fund at end of year
1966.....	\$1,578	\$982	² \$50	\$17	\$562
1967.....	2,601	2,192	66	20	925
1968.....	2,790	2,391	72	34	1,286
1969.....	2,879	2,607	78	45	1,625
1970.....	2,983	2,840	85	50	1,933
1971.....	3,327	3,055	92	55	2,186
1972.....	3,488	3,280	98	60	2,438
1973.....	3,929	3,516	105	68	2,814
1974.....	4,120	3,760	113	77	3,138
1975.....	4,267	4,028	121	84	3,460
1980.....	6,123	5,276	158	140	5,018
1985.....	7,038	6,823	205	236	7,681
1990.....	9,030	8,754	263	306	9,948

¹ Source: Department of Health, Education, and Welfare.

² Including administrative expenses incurred in 1965.

The 21-year-old worker, or indeed the 45-year-old worker, is not "prepaying" for his hospital benefits. He is really being taxed for the hospital benefits of those already retired and of the older workers who will retire before him. For example, the Department has estimated that a worker at age 50 who pays the full amount of the tax for the balance of his working years will have been taxed only to the extent of a fraction of the cost of his benefits.

*Relative hospital benefit cost and taxes paid under H.R. 6675 by selected age groups over 50 years of age*¹

[In billions]

	Cost of providing hospital benefits to selected age group	Taxes paid by selected age group	Cost younger workers are required to pay to provide benefits to selected age group
(1) Individuals 65 or over on Jan. 1, 1966.....	\$35	-----	\$35
(2) Individuals between 60 and 65 on Jan. 1, 1966.....	25	\$1	24
(3) Individuals between 50 and 60 on Jan. 1, 1966.....	80	6	74
(4) All individuals 50 or over on Jan. 1, 1966 ((1) through (3) above).....	\$140	\$7	\$133

¹ Source: Department of Health, Education, and Welfare.

HOSPITAL COST REIMBURSEMENT FORMULA DESTROYS QUALITY OF MEDICAL CARE

The committee bill embodies a wholly new concept of payment for the hospital services which will be supplied to the aged under the hospital benefits program. The bill provides that the payment to the providers of such services (hospitals) will be limited to the "reasonable cost" of the services to be determined in accordance with regulations to be issued by the Department of Health, Education, and Welfare.

In other words, it makes no difference what the hospital might customarily charge for room and board, radiotherapy, or any other of the multitudinous services available for the treatment of the patient. It is immaterial, in fact, what Blue Cross or any health insurer might pay for the same service. The bill presupposes that it will cost less to render the services to the aged. Actuarially, the cost estimates relied upon in the bill are predicated on the assumption that the Department will be able to buy hospital services for the aged at a "discount" rate.

The bill requires that the Department shall fix a price—namely, "reasonable cost"—for each and every service rendered by the hospital or nursing home. The bill does not specifically define "reasonable cost." However, in fixing the reasonable cost of such services, it is admitted that charges for bad debts, charity patients, and certain unabsorbed overhead will not be allocated as a cost of the services financed under the hospitalization program.

The committee was advised that there are some 5,000 hospitals which will participate in the program. Add to this an undetermined number of nursing homes and other providers of services. The so-called reasonable cost in each case will vary. This means that every provider of services will be required to analyze its cost for every service which may be supplied to the aged, and to negotiate and

agree with the agency administering the program on the price to be charged to the aged for such service.

The hospitals are for the most part nonprofit institutions. There is hardly a hospital in the country which does not embark upon various money-raising programs in order to make up the deficit between the charges and the cost of running the hospital. Any cost which is shifted from the overage 65 patients in the cost formula prescribed by the Department, must necessarily be paid by someone. Many of the hospitals are already faced with inadequate revenues. If the hospitals are to continue in operation, someone will have to pay for the charity patients, the bad debt losses, and the unabsorbed overhead. If the entire burden is shifted from the overage 65 patients to the other patients, this will inevitably increase hospitalization costs for the patients under age 65.

In lieu of this formula, the Republicans suggested that the hospital program reimburse the provider of services at the customary rate charged for such services. This was rejected on the grounds that it would result in an overpayment on account of the aged. The Department claimed that the "reasonable cost" for the aged, as contemplated by the committee bill, will be less than the Blue Cross rates.

The consequences of the adoption of the "reasonable cost" formula should be apparent. If the hospitals are prevented from charging the customary rates to the patients over age 65, hospital costs for patients under age 65 will have to be increased in order to make up the difference. In order to reduce its losses, when the patients under age 65 can no longer bear such increases, the hospital will be forced to curtail the quality of its service.

The Department will undoubtedly contend that the services offered to those aged 65 cannot be reduced because the Department will see that this is not done. In other words, in the final analysis, so long as the "reasonable cost" formula remains in the bill, hospital care for those over age 65—and the operations of the hospital itself—will necessarily be subject to control by the Department. This is essential if the Department is to prevent the hospital from taking the only course open to it in reducing its losses, namely, to cut back on its services to the patients over age 65 who are the cause of such losses.

REPUBLICANS OFFER BETTER PROPOSAL FOR COMPREHENSIVE HEALTH INSURANCE

OUTLINE OF REPUBLICAN COMPREHENSIVE HEALTH INSURANCE PROGRAM

We propose a program of comprehensive health insurance for everyone over age 65 equivalent to the medical insurance available to Government employees under the high option of the Government-wide indemnity plan. This plan has been described by the Department of Health, Education, and Welfare as providing the most comprehensive insurance available at this time. Our program would meet all of the medical needs of the aged, both in and out of the hospital. It will cover the catastrophic illness. It is both comprehensive in scope and comprehensive in effect.

Under this program, all persons aged 65 or over are eligible, on a uniform basis. Their participation would be voluntary; there would

be no means test. Enrollment would be during an initial enrollment period, followed by periodic enrollment periods.

For those under social security—or railroad retirement—enrollment would be exercised by an assignment of a premium contribution to be taken out of, or checked off, the individual's current social security benefit. Those not under social security would execute an application accompanying it with their initial premium contribution. State agencies would be granted an option to purchase the insurance for their old-age assistance and medical assistance for the aged recipients at a group rate.

Premium contributions by individuals would be based upon the cash benefits which they would either receive, or be entitled to receive upon reaching age 65. The premium would be 10 percent of the minimum social security benefit and 5 percent of the balance. Those receiving the lowest social security benefits would pay the least. The average premium contribution on the basis of the benefit levels in the committee bill would be about \$6.50 per month per person. Persons not under social security would pay a premium equivalent to the maximum contribution of an individual under social security. The remainder of the cost of the insurance would be paid by the Federal Government out of general revenues.

Benefits would be paid out of a national health insurance fund. The fund would receive as deposits the contributions of individuals, contributions from the social security system and Railroad Retirement Board on behalf of individuals covered under those systems, State contributions for OAA and MAA recipients, and annual appropriations from the Federal Treasury. The Secretary of the Treasury would administer the fund. The insurance program would be administered by the Department of Health, Education, and Welfare, which would be charged with general administration, recordkeeping, and so forth, but would not process the claims or bills of hospitals, physicians, and the like. The Surgeon General would contract with private agencies—Blue Cross-Blue Shield, for example—which would process and pay the claims of those furnishing services and would then be reimbursed from the national health insurance fund.

Under what we propose, more medical care can be provided for those over age 65 at a savings both to the Government and to the taxpayer. For the first full year of coverage, the net cost to the Treasury for financing the Republican health insurance program, after taking into account the additional tax revenues and the savings in other Federal programs attributable to the program, will amount to less than \$2 billion. While costs will increase—just as costs will increase under the programs in H.R. 6675—premium contributions will also increase under the Republican program. The taxpayer—or tomorrow's worker—does not bear the full brunt of the increases in hospital and other medical costs.

The Republican program also embodies an amendment to the Internal Revenue Code to provide for a special tax to recoup a part of the cost of the insurance from those participating who have incomes in excess of \$5,000 for a single person and in excess of \$10,000 for a married couple filing a joint return. In this manner, those over age 65, who are fully able to finance health insurance without Government aid, can participate in the program with the full knowledge that they are not passing on this cost to others.

REPUBLICAN PROPOSAL AVOIDS PROBLEMS INHERENT IN THE COMMITTEE
BILL

The Republican proposal for a national health insurance fund, financed partially through voluntary contributions and partially through the general revenues, avoids the problems inherent in the committee bill. Health insurance for the aged is not divided into separate programs requiring separate financing and separate administration. The aged are treated just as we treat our Federal employees. Adequate insurance is provided at a cost which is well within the means of those who do not qualify for State assistance.

The program provides comprehensive medical care. It is not misleading.

The insurance concept is completely voluntary. Since there is a cost to the insured, those who already have adequate programs paid for by their former employers or through associations and the like, may not elect the Government-sponsored program. To the extent that these do not participate, the cost to the Government is reduced.

The insurance concept is completely independent of the social security system. Social security benefits are used merely as a test of ability to pay in determining the amount of the premium. The assignment of a predetermined percentage of these benefits to the health insurance fund is the only relationship of the program to the social security system.

The premium contribution schedule embodies a relative needs test. For example, for a couple receiving the maximum social security benefit (\$203.85), the cost of the insurance will be \$13.00 per month. A couple receiving the minimum social security benefit (\$66) will be able to buy the same health insurance at a cost of \$5.50 per month. The amount of the Government subsidy thus varies with the economic status of the individual, as measured by social security benefits.

By including a contribution or premium charge, the cost is shared by the individual and the Government. This makes for a sounder program. This cost sharing will have a tendency to reduce excessive usage of the benefits.

The program preserves fully the role of the States in providing for those who are in need. Instead of blanketing in individuals receiving medical assistance under OAA and under MAA, as provided in the hospital benefit program of the committee bill, the States will determine the needs of these persons and are permitted to insure them as a group if the State elects to do so. It becomes possible to provide all recipients of medical care with the same type of basic protection, irrespective of their economic status. No distinction is made in our program between the person who participates on an individual basis, the social security recipient who elects to participate, the recipient of OAA and the recipient of MAA. All receive the same basic insurance policy.

In alternative, however, we also give the States the election under the Kerr-Mills Act, to offer alternate programs of private health insurance to the aged, which is the approach adopted in the Eldercare bills.

REPUBLICANS SUPPORT AMENDMENTS TO KERR-MILLS PROGRAM

The bill expands State programs for medical assistance to the aged, blind, and the disabled, and provides grants for maternal and child health care and crippled children's services. These amendments will unquestionably bring about better medical care for those in need under the State-administered programs of medical assistance for the aged, the blind, the disabled, and for dependent children.

The Republicans supported similar amendments before the Ways and Means Committee in the last Congress. We reaffirm that position. However, the proponents of medicare would not support the medical assistance amendments at that time because they felt that such action might jeopardize—because of reducing the need for—the hospitalization program provided in H.R. 1.

Not only do the Republicans fully support these amendments to the Kerr-Mills program, but we would enlarge upon the committee bill in this respect. We would add the complete concept embodied in the Eldercare bills (H.R. 3728 and H.R. 3801) introduced by two Republican members of the committee. Under these bills, voluntary private health insurance plans may be used as the insurance intermediary. State governments, assisted by Federal funds, could offer health insurance coverage to fit the individual needs of the aged. The cost of such coverage would be paid completely out of Federal-State funds for those individuals with incomes below means established by each State. For those individuals exceeding the minimum but less than a maximum, the State could pay a part of the cost. Eligibility would be determined solely on the basis of a simple statement of annual income submitted to the appropriate State authorities.

While much of the Eldercare bills is embodied in the committee bill, we believe that the States should be specifically authorized to adopt such programs under the Kerr-Mills Act. We propose to enlarge upon the committee amendments to the Kerr-Mills Act in order to make more specific the right of the States to enter into private contracts of insurance for the aged.

OASDI AMENDMENTS SUPPORTED BY REPUBLICANS

Substantially all of the amendments relating to the OASDI benefits were embodied in a bill (H.R. 288) introduced on January 4, 1965, by the ranking Republican member of the committee, and similar bills introduced by other Republicans (H.R. 3163, H.R. 3830, H.R. 3219, H.R. 4230, H.R. 4272, H.R. 4395, H.R. 4619, H.R. 4971, H.R. 5038, H.R. 5039, and H.R. 6404). These amendments could have been enacted into law long ago if considered separately from the so-called medicare program. In fact, some 20 million recipients (or their dependents) would already have been enjoying the benefits of these amendments if the proponents of medicare, at the direction of the administration, had not blocked enactment of the social security amendments in the last Congress.

Many of the amendments in the Republican bills (H.R. 288, 3161, 3219, and 3830) are now included in the committee bill. We fully support these amendments:

(1) A 7-percent increase in cash benefits, with a minimum increase of \$4 for the primary insurance amount.¹

¹ The Republican bills proposed a 7-percent increase in cash benefits with a minimum increase of \$5 in the primary insurance amount.

(2) A minimum benefit of \$35 for some 400,000 persons over age 72 who do not have the requisite work coverage to qualify for benefits under existing law.

(3) Liberalization of the earnings test for the aged who seek to supplement their social security benefits with part-time jobs.

(4) Extension of social security benefits for dependents attending school up to age 22 instead of age 18.

(5) Social security benefits for widows beginning at age 60, rather than at age 62.

(6) Liberalization of the gross income upon which farmers may elect to pay social security taxes.

(7) Recognition of the conscientious objection of certain long-established religious groups to the social security concept.

In addition to these amendments to the OASDI system, the Republican proposals also contained the amendments relating to the old-age assistance and other assistance programs administered by the States, which are presently included in H.R. 6675. Titles II, III, and IV of the committee bill are, for the most part, supported by the Republicans. We take satisfaction in the fact that many of these amendments—not included in the administration's bill (H.R. 1)—were contained in the bills introduced by the Republicans.

REPUBLICANS APPLAUD TAX RELIEF FOR THOSE UNDER AGE 65 CARRYING HEALTH INSURANCE

Although we have made tremendous gains in public acceptance of health and accident insurance over the past decade, the taxpayer, instead of being given an incentive to enroll himself or his family in a medical plan, is penalized for doing so. Under existing law, the medical expense deduction is limited to the amount in excess of 3 percent of the taxpayer's adjusted gross income. The 3-percent limitation effectively excludes the cost of health insurance. This penalizes the taxpayer who insures himself and his family through accident and health insurance. Today, as a practical matter, a person having adequate health insurance does not get a tax deduction for either insurance costs or medical costs.

For many years, the Republicans have sought to amend the tax laws so as to treat premiums paid on account of health and accident insurance differently from other medical expense in order that a taxpayer carrying such insurance will be placed on more nearly an equal basis with a taxpayer who does not insure his medical expenses.

The committee bill partially remedies this inequity. The bill provides a separate deduction (up to a maximum \$250 per year) for 50 percent of the cost of the taxpayer's expense for health insurance. The Republicans would prefer the allowance of the deduction in full. Nevertheless, we believe that "half a loaf is better than none," and we applaud the recognition, in the committee bill, of health insurance premiums as a separate deduction, not subject to the 3-percent exclusion.

JOHN W. BYRNES.
THOMAS B. CURTIS.
JAMES B. UTT.
JACKSON E. BETTS.
HERMAN T. SCHNEEBELI.
HAROLD R. COLLIER.
JOEL T. BROYHILL.
JAMES F. BATTIN.

ADDITIONAL SEPARATE VIEWS OF THE HONORABLE JOEL T. BROYHILL

The undersigned has joined with my Republican colleagues in the foregoing Separate Views opposing enactment of the so-called medicare program provisions of H.R. 6675, in the compulsory form in which the program was approved by the majority members of the Committee on Ways and Means.

I support the efforts to be made by the Republican minority during the House floor consideration of H.R. 6675 to delete the mandatory medicare provisions of the bill and substitute therefor a voluntary program of broader health care insurance. I file these additional separate views because I was one of the original 35 sponsors of the eldercare proposal as embodied in my bill, H.R. 3801, and I believe it appropriate to discuss the superiority of the eldercare proposal over the administration's medicare proposal in view of the broad support given the eldercare approach in the Congress.

My preference for the eldercare approach over the medicare plan is based on the fact that the eldercare proposal avoids compulsion, minimizes Federal regimentation, and allows a comprehensive range of benefits under State administered programs. Under eldercare the extent of aid to the recipient is based on his need for Government assistance in meeting his health-care requirements without requiring a "social-worker type" needs test.

The eldercare proposal would work as follows: Voluntary private health insurance plans would be used as the insuring intermediaries. State governments, assisted by Federal funds, would offer health insurance coverage to fit a variety of individual needs of the aged. The cost of such coverage would be borne completely by Government for those individuals with incomes falling below minimum limits set by each State. For those individuals with incomes exceeding the minimum but less than a maximum, the State would pay a part of the cost. For those individuals whose incomes exceed maximum limits, the State would pay nothing. Aged individuals would periodically make a simple statement of annual income to the State. On the basis of this income statement alone would eligibility be determined.

Principal reasons for opposing medicare

Medicare should not be enacted because:

- (1) The so-called medicare program is a compulsory Federal plan that would impose additional regressive payroll taxes on the current working population regardless of *inability* to pay; partial health benefits are made available to the retired population regardless of individual *ability* to be self-supporting—rich and poor alike. (See tables 1 and 2 for OASDI tax rate schedules and table 3 for medicare tax rate schedule. Tables also show tax amount per individual. Tables 5 and 6 set forth data with

respect to combined OASDI and medicare tax rates and amounts. Tables follow at the end of these additional views.)

(2) Medicare would establish a massive Federal program financed by social security and administered by a central bureaucracy and would violate the established concept that the echelon of government closest to the people can be more efficient and responsive in administration of social programs.

(3) Medicare would initiate what would ultimately become a Federal monopoly in regard to the financing and rendering of health care with respect to our aged to the detriment of endeavors of the private sector; this result would impair the quality of health care, retard the advancement of medical science, and displace private insurance.

(4) Medicare would for the first time inject into our OASDI system *service* benefits as distinguished from predeterminable *cash* benefits with the consequence that unpredictable costs and overutilization would jeopardize the soundness and acceptability of the social security program as well as necessitate a vast and costly expansion of health care facilities.

(5) The consensus of nongovernmental actuaries experienced in health insurance matters holds that the medicare program is underfinanced; but even the inadequate financing provisions of the bill would mean that for many taxpayers more would be paid in social security taxes than would be paid in income taxes.

(6) The economic thrust of the higher employment taxes necessitated by the medicare programs would have immediate adverse impact on job opportunities and the problem would be further aggravated by the certain expansion of the program once started. (See table 4 for estimated aggregate payroll taxes.)

Principal reasons for introducing eldercare

The eldercare program, embodied in H.R. 3801, was introduced for committee consideration as a preferable alternative to medicare because:

(1) The eldercare proposal is a noncompulsory program permitting health care under State administered programs aimed at providing complete care for aged persons requiring help in meeting their health expenses without a "social-worker type" means test.

(2) The proposal would provide for State administration and the utilization of private insurance carriers, thereby assuring responsible and responsive administration.

(3) Eldercare would minimize the intrusion of inflexible governmental management on medical facilities and professional services.

(4) The eldercare proposal would neither interfere with nor endanger the established concept of confining OASDI benefits to cash payments and would avoid the risky adventure of service benefits—an adventure that is failing in virtually every other major country.

(5) The eldercare proposal would not require the imposition of higher regressive payroll taxes and it would not jeopardize the actuarial status of the present OASDI system.

GENERAL DISCUSSION

The biennial political issue of compulsory Federal health care under social security has been pending before the Congress for 20 years. In that interim there has been no meaningful fundamental improvement contained in the various modifications that have been advocated in the compulsory social security approach. The only variations in the different proposals advanced from time to time are: (1) Curtailments in the suggested benefits to make the alleged cost politically salable, (2) arbitrary adjustments in eligibility requirements and, more recently, (3) a new catchword title—"Medicare."

In this 20-year period during which the Congress has rejected compulsory Federal health programs, the Congress has acted to establish sound Federal-State voluntary programs capable of meeting the health needs of citizens unable to defray the financial burdens of their own health requirements. The most recent instance of responsible action in this regard occurred with the enactment of the Kerr-Mills program.

There has also occurred in this 20-year period a phenomenal growth in the proportion of our aged population covered by private health insurance protection so that today substantially more than 60 percent of persons 65 years and over have coverage. In the past 10 years the number of aged covered by private insurance has more than tripled and the percentage of those so protected is expected to surpass 75 percent by 1969. Now the Congress is being called upon to provide a compulsory political solution to a medical problem by enacting a plan that would impair State administered programs and would destroy the incentive for the financially able aged to provide for themselves through insurance.

The membership of the House of Representatives, in acting on the medicare political palliative should be cognizant of the meaningful fact that the two groups most knowledgeable of the medical and actuarial implications of the medicare proposal oppose its enactment—these groups are the physicians and the health insurance industry. The concerns expressed by these groups are sustained by events throughout the world where government health programs have reached the critical juncture of unforeseen increases in cost and declining quality of medical service. It is not by accident that the U.S. citizens have available to them the highest standard of health care in the world under our free enterprise system. The enactment of medicare will inescapably impair the quality and increase the cost of health care in this country similar to the deteriorating standards and increasing costs being experienced in such countries as Great Britain, France, and Italy.

The proponents of compulsory health care under social security have provided a separate "health" trust fund to alleviate concern over the impact the provision of medical service benefits may have on the system's ability to meet cash benefit obligations. This same "precautionary safeguard" was attempted in the establishment of the separate Federal disability insurance trust fund under social security in 1956, which will only be saved from insolvency in 1966 by a provision in the committee's bill which allocates a larger percentage of the payroll tax which supports all facets of the OASDI program.

The potential for the impairment of the solvency of the new "health" trust fund arises in part from the fact that present aged beneficiaries

would be eligible for benefits under the program without any contribution to the trust fund for health insurance benefits. Concern over this problem was expressed in September 1964 by the able chairman of the Committee on Ways and Means when he said of medicare:

* * * a further very serious problem is the effect which the assumption of the liability for the hospital costs for all the currently retired persons will have on the social security program as a whole. I do not believe that it is generally understood that this unfunded liability would amount to at least \$33 billion. It must be realized that the currently retired individuals under the social security program have not paid any taxes as such for hospital insurance benefits. This is where the prepayment argument * * * completely breaks down.

The esteemed chairman of the Committee on Ways and Means has worked diligently and conscientiously to provide an adequate and sound social security program; and it is because of that fact that I believe his admonition should be brought to the attention of the House membership.

Thus, this unfunded liability makes it patent that to claim medicare is based on an insurance principle is to clutch at an illusion. The unfunded obligations of the present OASDI program, which currently exceed \$300 billion under present law, will have many more billions of unfunded benefit commitments added by the institution of the new "medicare" program with its schedule of deferred tax increases which does not reach its ultimate effect until January 1, 1987. The first population group that will bear the full brunt of the tax burden is the group of citizens to be born 6 years from now; and that group will be called upon to pay for its benefits as well as share in defraying the benefit costs of the presently retired and of those now in the working force.

It is also to be noted that the present law limitation on earned income by beneficiaries for eligibility for cash benefits, the so-called retirement test, would not be applicable with respect to the health service benefits. The service benefits provided in this bill will create additional inequities in the OASDI program in that persons aged 65 who become sick will be eligible for benefits without paying and taxes for these added benefits, whereas a person aged 60 who is in need and has paid increased taxes will be denied benefits.

CONCLUSION

Although there are many provisions in H.R. 6675 which I believe to be meritorious, such as were referred to in the foregoing Separate Views, the compulsory health care features of the bill threaten danger to the entire social security structure. The melancholy prospect for medicare is that it will retard, not advance, the Nation's health and welfare. In opposing this medicare program for the compelling reasons presented, I pledge myself to continued endeavors to have favorable action taken on a sounder and more equitable approach to meeting the medical needs of our aged citizens. I respectfully urge my colleagues in the House to join the Republican members of the Committee on Ways and Means in this effort.

JOEL T. BROYHILL, *Member of Congress.*

TABLE 1.—*Tax rate, tax base, and tax amount applicable to employers and employees (each) under present law and under H.R. 6675*¹

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE PROGRAM, 1965-87 AND AFTER

Year	Tax rate, employer and employee (each)		Tax base		Tax per employee with base wage under bill ²			
					Amount of tax		Increase under bill	
	Under present law	Under bill	Under present law	Under bill	Under present law	Under bill	Over present law	Over 1965
	<i>Percent</i>	<i>Percent</i>						
1965	3.625	3.625	\$4,800	\$4,800	\$174	\$174.00		
1966	4.125	4.000	4,800	5,600	198	224.00	\$26.00	\$50.00
1967	4.125	4.000	4,800	5,600	198	224.00	26.00	50.00
1968	4.625	4.000	4,800	5,600	222	224.00	2.00	50.00
1969-70	4.625	4.400	4,800	5,600	222	246.40	24.40	72.40
1971-72	4.625	4.400	4,800	6,600	222	290.40	68.40	116.40
1973-75	4.625	4.800	4,800	6,600	222	316.80	94.80	142.80
1976-79	4.625	4.800	4,800	6,600	222	316.80	94.80	142.80
1980-86	4.625	4.800	4,800	6,600	222	316.80	94.80	142.80
1987 and after	4.625	4.800	4,800	6,600	222	316.80	94.80	142.80

¹ As described in Ways and Means Committee press release issued on Mar. 24, 1965, which summarizes the bill.² Employers pay same amount on behalf of such employees.

Source: Staff of the Joint Committee on Internal Revenue Taxation.

TABLE 2.—*Tax rate, tax base, and tax amount applicable to self-employed persons under present law and under H.R. 6675*¹

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE PROGRAM, 1965-87 AND AFTER

Year	Tax rate		Tax base		Tax per self-employed with base earnings under bill			
					Amount of tax		Increase under bill	
	Under present law	Under bill	Under present law	Under bill	Under present law	Under bill	Over present law	Over 1965
	<i>Percent</i>	<i>Percent</i>						
1965	5.4	5.4	\$4,800	\$4,800	\$259.20	\$259.20		
1966	6.2	6.0	4,800	5,600	297.60	336.00	\$38.40	\$76.80
1967	6.2	6.0	4,800	5,600	297.60	336.00	38.40	76.80
1968	6.9	6.0	4,800	5,600	331.20	336.00	4.80	76.80
1969-70	6.9	6.6	4,800	5,600	331.20	369.60	38.40	110.40
1971-72	6.9	6.6	4,800	6,600	331.20	435.60	104.40	176.40
1973-75	6.9	7.0	4,800	6,600	331.20	462.00	130.80	202.80
1976-79	6.9	7.0	4,800	6,600	331.20	462.00	130.80	202.80
1980-86	6.9	7.0	4,800	6,600	331.20	462.00	130.80	202.80
1987 and after	6.9	7.0	4,800	6,600	331.20	462.00	130.80	202.80

¹ As described in Ways and Means Committee press release, issued on Mar. 24, 1965, which summarizes the bill.

Source: Staff of the Joint Committee on Internal Revenue Taxation.

TABLE 3.—*Tax rate, tax base and tax amount, applicable to employers, employees, and self-employed persons under the basic health insurance program of H.R. 6675*¹

1965-87 AND AFTER

Year	Tax on employer, employee, and self-employed (each)		
	Tax rate (percent)	Tax base	Tax amount ²
1965.....			
1966.....	0.35	\$5,600	\$19.60
1967.....	.50	5,600	28.00
1968.....	.50	5,600	28.00
1969-70.....	.50	5,600	28.00
1971-72.....	.50	6,600	33.00
1973-75.....	.55	6,600	36.30
1976-79.....	.60	6,600	39.60
1980-86.....	.70	6,600	46.20
1987 and after.....	.80	6,600	52.80

¹ As described in Ways and Means Committee press release issued on Mar. 24, 1965, which summarizes the bill.² For each self-employed person and employee with earnings or wage equal to or in excess of the tax base; employers pay same amount on behalf of such employees.

Source: Staff of the Joint Committee on Internal Revenue Taxation.

TABLE 4.—*Estimated aggregate taxes on employers, employees, and self-employed persons under present law and under H.R. 6675*¹

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE PROGRAM, 1965-72 AND BASIC HEALTH INSURANCE PROGRAM, 1965-75, 1980, 1985, AND 1990

[In billions of dollars]

Year	Present law			H.R. 6675			
	Old-age and survivors insurance program	Disability insurance program	Total	Old-age and survivors insurance program	Disability insurance program	Basic health insurance program	Total
1965.....	\$16.0	\$1.2	\$17.2	\$16.0	\$1.2		\$17.2
1966.....	18.5	1.2	19.7	18.5	1.8	\$1.6	21.9
1967.....	19.4	1.3	20.7	19.7	2.0	2.6	24.3
1968.....	22.2	1.3	23.5	20.3	2.1	2.8	25.2
1969.....	23.3	1.3	24.6	22.9	2.2	2.9	28.0
1970.....	24.0	1.4	25.4	24.0	2.2	3.0	29.2
1971.....	24.7	1.4	26.1	25.9	2.4	3.3	31.6
1972.....	25.4	1.4	26.8	27.2	2.5	3.5	33.2
1973.....	(2)	(2)	(2)	(2)	(2)	3.9	(2)
1974.....	(2)	(2)	(2)	(2)	(2)	4.1	(2)
1975.....	(2)	(2)	(2)	(2)	(2)	4.3	(2)
1980.....	(2)	(2)	(2)	(2)	(2)	6.1	(2)
1985.....	(2)	(2)	(2)	(2)	(2)	7.0	(2)
1990.....	(2)	(2)	(2)	(2)	(2)	9.0	(2)

¹ As described in Ways and Means Committee press release, issued on Mar. 24, 1965, which summarizes the bill.² Not available.

Source: Compiled by staff of the Joint Committee on Internal Revenue Taxation from data supplied by Social Security Administration.

TABLE 5.—*Combined tax rate on employer and employee under present law and under H.R. 6675*¹

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE PROGRAM AND BASIC HEALTH INSURANCE PROGRAM, 1965-87 AND AFTER

[In percent]

Year	Combined tax rate on employer and employee							
	Old-age, survivors, and disability insurance program		Basic health insurance program		Old-age, survivors, and disability insurance program and basic health insurance program			
	Under present law	Under bill	Under present law	Under bill	Under present law	Under bill	Change under bill	
							Over present law	Over 1965
1965	7.25	7.25			7.25	7.25		
1966	8.25	8.00		0.70	8.25	8.70	+0.45	+1.45
1967	8.25	8.00		1.00	8.25	9.00	+ .75	+1.75
1968	9.25	8.00		1.00	9.25	9.00	- .25	+1.75
1969-70	9.25	8.80		1.00	9.25	9.80	+ .55	+2.55
1971-72	9.25	8.80		1.00	9.25	9.80	+ .55	+2.55
1973-75	9.25	9.60		1.10	9.25	10.70	+1.45	+3.45
1976-79	9.25	9.60		1.20	9.25	10.80	+1.55	+3.55
1980-86	9.25	9.60		1.40	9.25	11.00	+1.75	+3.75
1987 and after	9.25	9.60		1.60	9.25	11.20	+1.95	+3.95

¹ As introduced in the House of Representatives on Mar. 24, 1965.

Source: Staff of the Joint Committee on Internal Revenue Taxation.

TABLE 6.—*Combined tax on employer and employee under present law and under H.R. 6675*^{1 2}

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE PROGRAM AND BASIC HEALTH INSURANCE PROGRAM, 1965-87 AND AFTER

Year	Combined tax on employer and employee							
	Old-age, survivors, and disability insurance program		Basic health insurance program		Old-age, survivors, and disability insurance program and basic health insurance program			
	Under present law	Under bill	Under present law	Under bill	Under present law	Under bill	Increase under bill	
							Over present law	Over 1965
1965	\$348	\$348.00			\$348	\$348.00		
1966	396	448.00		\$39.20	396	487.20	\$91.20	\$139.20
1967	396	448.00		56.00	396	504.00	108.00	156.00
1968	444	448.00		56.00	444	504.00	60.00	156.00
1969-70	444	492.80		56.00	444	548.80	104.80	200.80
1971-72	444	580.80		66.00	444	646.80	202.80	298.80
1973-75	444	633.60		72.60	444	706.20	262.20	358.20
1976-79	444	633.60		79.20	444	712.80	268.80	364.80
1980-86	444	633.60		92.40	444	726.00	282.00	378.00
1987 and after	444	633.60		105.60	444	739.20	295.20	391.20

¹ For employee with wage equal to or in excess of the tax base under the bill.² As introduced in the House of Representatives on Mar. 24, 1965.

Source: Staff of the Joint Committee on Internal Revenue Taxation.

89TH CONGRESS
1ST SESSION

H. R. 6675

[Report No. 213]

IN THE HOUSE OF REPRESENTATIVES

MARCH 24, 1965

Mr. MILLS introduced the following bill; which was referred to the Committee on Ways and Means

MARCH 29, 1965

Committed to the Committee of the Whole House on the State of the Union
and ordered to be printed

A BILL

To provide a hospital insurance program for the aged under the Social Security Act with a supplementary health benefits program and an expanded program of medical assistance, to increase benefits under the Old-Age, Survivors, and Disability Insurance System, to improve the Federal-State public assistance programs, and for other purposes.

- 1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 That this Act, with the following table of contents, may be
4 cited as the "Social Security Amendments of 1965".

J. 35-001—1

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TITLE IV—PUBLIC ASSISTANCE AMENDMENTS—Continued

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- SEC. 407. Extension of grace period for disregarding certain income for States where legislature has not met in regular session.
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1 TITLE I—HEALTH INSURANCE FOR THE AGED

2 AND MEDICAL ASSISTANCE

3 SHORT TITLE

4 SEC. 100. This title may be cited as the "Health Insur-

5 ance for the Aged Act".

6 PART 1—HEALTH INSURANCE BENEFITS FOR THE AGED

7 ENTITLEMENT TO HOSPITAL INSURANCE

8 BENEFITS

9 SEC. 101. Title II of the Social Security Act is amended

10 by adding at the end thereof the following new section:

11 "ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS

12 "SEC. 226. (a) Every individual who—

13 " (1) has attained the age of 65, and

14 " (2) is entitled to monthly insurance benefits under

15 section 202 or is a qualified railroad retirement bene-

16 ficiary,

1 shall be entitled to hospital insurance benefits under part A
2 of title XVIII for each month for which he meets the con-
3 dition specified in paragraph (2), beginning with the first
4 month after June 1966 for which he meets the conditions
5 specified in paragraphs (1) and (2).

6 “(b) For purposes of subsection (a) —

7 “(1) entitlement of an individual to hospital insur-
8 ance benefits for a month shall consist of entitlement to
9 have payment made under, and subject to the limitations
10 in, part A of title XVIII on his behalf for inpatient hos-
11 pital services, post-hospital extended care services, post-
12 hospital home health services, and outpatient hospital
13 diagnostic services (as such terms are defined in part C
14 of title XVIII) furnished him in the United States dur-
15 ing such month; except that (A) no such payment may
16 be made for post-hospital extended care services fur-
17 nished before January 1967, and (B) no such payment
18 may be made for post-hospital extended care services or
19 post-hospital home health services unless the discharge
20 from the hospital required to qualify such services for
21 payment under part A of title XVIII occurred after
22 June 30, 1966, or on or after the first day of the month
23 in which he attains age 65, whichever is later; and

24 “(2) an individual shall be deemed entitled to
25 monthly insurance benefits under section 202, or to be

1 a qualified railroad retirement beneficiary, for the month
2 in which he died if he would have been entitled to
3 such benefits, or would have been a qualified railroad
4 retirement beneficiary, for such month had he died in
5 the next month.

6 “(c) For purposes of this section, the term ‘qual-
7 ified railroad retirement beneficiary’ means an individual
8 whose name has been certified to the Secretary by the
9 Railroad Retirement Board under section 21 of the Railroad
10 Retirement Act of 1937. An individual shall cease to be a
11 qualified railroad retirement beneficiary at the close of the
12 month preceding the month which is certified by the Rail-
13 road Retirement Board as the month in which he ceased to
14 meet the requirements of section 21 of the Railroad Retire-
15 ment Act of 1937.

16 “(d) For entitlement to hospital insurance benefits in
17 the case of certain uninsured individuals, see section 103
18 of the Social Security Amendments of 1965.”

19 HOSPITAL INSURANCE BENEFITS AND SUPPLEMENTARY
20 HEALTH INSURANCE BENEFITS

21 SEC. 102. (a) The Social Security Act is amended by
22 adding after title XVII the following new title:

1 "TITLE XVIII—HEALTH INSURANCE FOR THE
2 AGED

3 "PROHIBITION AGAINST ANY FEDERAL INTERFERENCE

4 "SEC. 1801. Nothing in this title shall be construed to
5 authorize any Federal officer or employee to exercise any
6 supervision or control over the practice of medicine or the
7 manner in which medical services are provided, or over the
8 selection, tenure, or compensation of any officer or employee
9 of any institution, agency, or person providing health serv-
10 ices; or to exercise any supervision or control over the
11 administration or operation of any such institution, agency,
12 or person.

13 "FREE CHOICE BY PATIENT GUARANTEED

14 "SEC. 1802. Any individual entitled to insurance bene-
15 fits under this title may obtain health services from any in-
16 stitution, agency, or person qualified to participate under this
17 title if such institution, agency, or person undertakes to pro-
18 vide him such services.

19 "OPTION TO INDIVIDUALS TO OBTAIN OTHER HEALTH
20 INSURANCE PROTECTION

21 "SEC. 1803. Nothing contained in this title shall be
22 construed to preclude any State from providing, or any in-

1 dividual from purchasing or otherwise securing, protection
2 against the cost of any health services.

3 “PART A—HOSPITAL INSURANCE BENEFITS
4 FOR THE AGED

5 “DESCRIPTION OF PROGRAM

6 “SEC. 1811. The insurance program for which entitle-
7 ment is established by section 226 provides basic protection
8 against the costs of hospital and related post-hospital services
9 in accordance with this part for individuals who are age 65
10 or over and are entitled to retirement benefits under title II
11 of this Act or under the railroad retirement system.

12 “SCOPE OF BENEFITS

13 “SEC. 1812. (a) The benefits provided to an individual
14 by the insurance program under this part shall consist of en-
15 titlement to have payment made on his behalf (subject to the
16 provisions of this part) for—

17 “(1) inpatient hospital services for up to 60 days
18 during any spell of illness;

19 “(2) post-hospital extended care services for up to
20 20 days (or up to 100 days in certain circumstances)
21 during any spell of illness;

22 “(3) post-hospital home health services for up to
23 100 visits (during the one-year period described in sec-
24 tion 1861 (n)) after the beginning of one spell of illness
25 and before the beginning of the next; and

1 “(4) outpatient hospital diagnostic services.

2 “(b) Payment under this part for services furnished an
3 individual during a spell of illness may not (subject to
4 subsections (c) and (d)) be made for—

5 “(1) inpatient hospital services furnished to him
6 during such spell after such services have been furnished
7 to him for 60 days during such spell; or

8 “(2) post-hospital extended care services furnished
9 to him during such spell after such services have been
10 furnished to him for 20 days during such spell.

11 “(c) The 20 days provided by subsection (b) (2) shall
12 be increased (but by not more than 80 days) by twice the
13 number by which the days for which the individual has
14 already been furnished inpatient hospital services in the spell
15 of illness are less than 60. The individual may terminate the
16 application of this subsection with respect to any day (and
17 the remaining days in the spell of illness) by an election
18 made at such time and in such manner as may be prescribed
19 by regulations. If the number of days of post-hospital ex-
20 tended care services in the spell of illness has been increased
21 pursuant to this subsection, a corresponding reduction (on
22 the basis of one day of inpatient hospital services for each
23 two days of post-hospital extended care services in excess of
24 20 plus, where the number of such days of post-hospital
25 extended care services is an odd number, one day of inpatient

1 hospital services) shall be made in the number of days allow-
2 able under subsection (b) (1) for the same spell of illness.

3 “(d) If an individual is an inpatient of a tuberculosis
4 hospital on the first day of the first month for which he is
5 entitled to benefits under this part, the days on which he
6 was an inpatient of such a hospital in the 60-day period im-
7 mediately before such first day shall be included in deter-
8 mining the 60-day limit under subsection (b) (1).

9 “(e) Payment under this part may be made for post-
10 hospital home health services furnished an individual only
11 during the one-year period described in section 1861 (n)
12 following his most recent hospital discharge which meets the
13 requirements of such section, and only for the first 100 visits
14 in such period. The number of visits to be charged for pur-
15 poses of the limitation in the preceding sentence, in connec-
16 tion with items or services described in section 1861 (m),
17 shall be determined in accordance with regulations.

18 “(f) For purposes of subsections (b), (c), (d), and (e),
19 inpatient hospital services, post-hospital extended care serv-
20 ices, and post-hospital home health services shall be taken into
21 account only if payment is or would be, except for this sec-
22 tion or the failure to comply with the request and certification
23 requirements of or under section 1814 (a), made with
24 respect to such services under this part.

25 “(g) For definition of ‘spell of illness’, and for defini-
26 tions of other terms used in this part, see section 1861.

1 "DEDUCTIBLES

2 "SEC. 1813. (a) (1) Payment for inpatient hospital
3 services furnished an individual during any spell of illness
4 shall be reduced by a deduction equal to the inpatient hospital
5 deductible; except that such deductible shall itself be reduced
6 by any deduction imposed under paragraph (2) with respect
7 to a diagnostic study by the same hospital which began
8 before but did not end more than 20 days before the first day
9 of such spell of illness or, if less, the charges imposed with
10 respect to the individual for the outpatient hospital diagnostic
11 services provided during such study.

12 "(2) Payment for outpatient hospital diagnostic services
13 furnished an individual during a diagnostic study shall be
14 reduced by a deduction equal to one-half of the inpatient
15 hospital deductible which is applicable to spells of illness
16 beginning in the same calendar year as such diagnostic study.
17 For purposes of the preceding sentence and paragraph (1),
18 a diagnostic study for any individual consists of the out-
19 patient hospital diagnostic services provided by (or under
20 arrangements made by) the same hospital during the 20-day
21 period beginning on the first day (not included in a previous
22 diagnostic study) on which he is entitled to hospital insur-
23 ance benefits under section 226 and on which outpatient
24 hospital diagnostic services are furnished him.

25 "(3) Payment to any provider of services under this

1 part for services furnished an individual during any spell of
2 illness shall be further reduced by an amount equal to the
3 cost of the first three pints of whole blood furnished to him as
4 part of such services during such spell of illness.

5 “(b) (1) The inpatient hospital deductible which shall
6 be applicable for the purposes of subsection (a) shall be \$40
7 in the case of any spell of illness or diagnostic study begin-
8 ning before 1969.

9 “(2) The Secretary shall, between July 1 and October
10 1 of 1968, and of each year thereafter, determine and promul-
11 gate the inpatient hospital deductible which shall be appli-
12 cable for the purposes of subsection (a) in the case of any
13 spell of illness or diagnostic study beginning during the suc-
14 ceeding calendar year. Such inpatient hospital deductible
15 shall be equal to \$40 multiplied by the ratio of (A) the cur-
16 rent average per diem rate for inpatient hospital services for
17 the calendar year preceding the promulgation, to (B) the
18 current average per diem rate for such services for 1966.
19 Any amount determined under the preceding sentence which
20 is not a multiple of \$5 shall be rounded to the nearest multiple
21 of \$5 (or, if it is midway between two multiples of \$5, to the
22 next higher multiple of \$5). The current average per diem
23 rate for any year shall be determined by the Secretary on the
24 basis of the best information available to him (at the time the
25 determination is made) as to the amounts paid under this part

1 on account of inpatient hospital services furnished during such
2 year, by hospitals which have agreements in effect under
3 section 1866, to individuals who are entitled to hospital in-
4 surance benefits under section 226, plus the amount which
5 would have been so paid but for subsection (a) (1) of this
6 section.

7 "CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR
8 SERVICES

9 "Requirement of Requests and Certifications

10 "SEC. 1814. (a) Except as provided in subsection (d),
11 payment for services furnished an individual may be made
12 only to providers of services which are eligible therefor under
13 section 1866 and only if—

14 "(1) written request, signed by such individual
15 except in cases in which the Secretary finds it impracti-
16 cable for the individual to do so, is filed for such payment
17 in such form, in such manner, within such time, and by
18 such person or persons as the Secretary may by regula-
19 tion prescribe;

20 "(2) a physician certifies (and recertifies, where
21 such services are furnished over a period of time, in such
22 cases, with such frequency, and accompanied by such
23 supporting material, appropriate to the case involved,
24 as may be provided by regulations, except that the first
25 of such recertifications shall be required in each case of

1 inpatient hospital services not later than the 20th day of
2 such period) that—

3 “(A) in the case of inpatient hospital services
4 (other than inpatient tuberculosis hospital services),
5 such services are or were required to be given on
6 an inpatient basis for such individual’s medical treat-
7 ment, or that inpatient diagnostic study is or was
8 medically required and such services are or were
9 necessary for such purpose;

10 “(B) in the case of inpatient tuberculosis hos-
11 pital services, such services are or were required to
12 be given on an inpatient basis, by or under the
13 supervision of a physician, for the treatment of an
14 individual for tuberculosis; and such treatment can
15 or could reasonably be expected to (i) improve the
16 condition for which such treatment is or was neces-
17 sary or (ii) render the condition noncommunicable;

18 “(C) in the case of post-hospital extended care
19 services, such services are or were required to be
20 given on an inpatient basis because the individual
21 needs or needed skilled nursing care on a con-
22 tinuing basis for any of the conditions with respect
23 to which he was receiving inpatient hospital services
24 (or services which would constitute inpatient hos-
25 pital services if the institution met the requirements

1 of paragraphs (6) and (8) of section 1861 (e))
2 prior to transfer to the extended care facility
3 or for a condition requiring such extended care serv-
4 ices which arose after such transfer and while he was
5 still in the facility for treatment of the condition or
6 conditions for which he was receiving such inpatient
7 hospital services;

8 “(D) in the case of post-hospital home health
9 services, such services are or were required because
10 the individual is or was confined to his home (ex-
11 cept when receiving items and services referred to
12 in section 1861 (m) (7)) and needed skilled nursing
13 care on an intermittent basis, or physical or speech
14 therapy, for any of the conditions with respect to
15 which he was receiving inpatient hospital services
16 (or services which would constitute inpatient hos-
17 pital services if the institution met the requirements
18 of paragraphs (6) and (8) of section 1861 (e))
19 or post-hospital extended care services; a plan for
20 furnishing such services to such individual has been
21 established and is periodically reviewed by a physi-
22 cian; and such services are or were furnished while
23 the individual was under the care of a physician; or

24 “(E) in the case of outpatient hospital diag-

1 nostic services, such services are or were required
2 for diagnostic study;

3 “(3) in the case of inpatient tuberculosis hospital
4 services, the services are those which the records of the
5 hospital indicate were furnished to the individual during
6 periods when he was receiving treatment which could
7 reasonably be expected to (A) improve his condition or
8 (B) render it noncommunicable;

9 “(4) with respect to inpatient hospital services fur-
10 nished such individual after the 20th day of a continuous
11 period of such services and with respect to post-hospital
12 extended care services furnished after such day of a
13 continuous period of such services as may be prescribed
14 in or pursuant to regulations, there was not in effect, at
15 the time of admission of such individual to the hospital or
16 extended care facility, as the case may be, a decision
17 under section 1866 (d) (based on a finding that utiliza-
18 tion review of long-stay cases is not being made in such
19 hospital or facility) ; and

20 “(5) with respect to inpatient hospital services or
21 post-hospital extended care services furnished such in-
22 dividual during a continuous period, a finding has not
23 been made (by the physician members of the committee
24 or group, as described in section 1861 (k) (4)) pursuant
25 to the system of utilization review that further inpatient

1 hospital services or further post-hospital extended care
2 services, as the case may be, are not medically necessary;
3 except that, if such a finding has been made, payment
4 may be made for such services furnished before the 4th
5 day after the day on which the hospital or extended care
6 facility, as the case may be, received notice of such
7 finding.

8 To the extent provided by regulations, the certification and
9 recertification requirements of paragraph (2) shall be
10 deemed satisfied where, at a later date, a physician makes
11 certification of the kind provided in subparagraph (A),
12 (B), (C), (D), or (E) of paragraph (2) (whichever
13 would have applied), but only where such certification is
14 accompanied by such medical and other evidence as may be
15 required by such regulations.

16 "Reasonable Cost of Services

17 "(b) The amount paid to any provider of services with
18 respect to services for which payment may be made under
19 this part shall be the reasonable cost of such services, as
20 determined under section 1861 (v).

21 "No Payments to Federal Providers of Services

22 "(c) No payment may be made under this part (except
23 under subsection (d)) to any Federal provider of services,
24 except a provider of services which the Secretary determines
25 is providing services to the public generally as a community

1 institution or agency; and no such payment may be made
2 to any provider of services for any item or service which
3 such provider is obligated by a law of, or a contract with,
4 the United States to render at public expense.

5 “Payments for Emergency Hospital Services

6 “(d) Payments shall also be made to any hospital for
7 inpatient hospital services or outpatient hospital diagnostic
8 services furnished, by the hospital or under arrangements
9 (as defined in section 1861(w)) with it, to an individual
10 entitled to hospital insurance benefits under section 226 even
11 though such hospital does not have an agreement in effect
12 under this title if (A) such services were emergency serv-
13 ices and (B) the Secretary would be required to make such
14 payment if the hospital had such an agreement in effect and
15 otherwise met the conditions of payment hereunder. Such
16 payments shall be made only in the amounts provided
17 under subsection (b) and then only if such hospital agrees
18 to comply, with respect to the emergency services provided,
19 with the provisions of section 1866(a).

20 “Payment for Inpatient Hospital Services Prior to Notifica-
21 tion of Noneligibility

22 “(e) Notwithstanding that an individual is not entitled
23 to have payment made under this part for inpatient hospital
24 services furnished by any hospital, payment shall be made to
25 such hospital (unless it elects not to receive such payment

1 or, if payment has already been made by or on behalf of such
2 individual, fails to refund such payment within the time
3 specified by the Secretary) for such services which are
4 furnished to the individual prior to notification to such
5 hospital from the Secretary of his lack of entitlement, if
6 such payments are precluded only by reason of section
7 1812 and if such hospital complies with the requirements
8 of and regulations under this title with respect to such
9 payments, has acted in good faith and without knowledge of
10 such lack of entitlement, and has acted reasonably in assum-
11 ing entitlement existed. Payment under the preceding
12 sentence may not be made for services furnished an indi-
13 vidual pursuant to any admission after the 6th elapsed
14 day (not including as an elapsed day Saturday, Sunday, or a
15 legal holiday) after the day on which such admission oc-
16 curred.

17 "PAYMENT TO PROVIDERS OF SERVICES

18 "SEC. 1815. The Secretary shall periodically determine
19 the amount which should be paid under this part to each pro-
20 vider of services with respect to the services furnished by
21 it, and the provider of services shall be paid, at such time
22 or times as the Secretary believes appropriate (but not less
23 often than monthly) and prior to audit or settlement by the
24 General Accounting Office, from the Federal Hospital Insur-
25 ance Trust Fund, the amounts so determined, with necessary

1 adjustments on account of previously made overpayments or
2 underpayments; except that no such payments shall be made
3 to any provider unless it has furnished such information as
4 the Secretary may request in order to determine the amounts
5 due such provider under this part for the period with respect
6 to which the amounts are being paid or any prior period.

7 "USE OF PUBLIC AGENCIES OR PRIVATE ORGANIZATIONS
8 TO FACILITATE PAYMENT TO PROVIDERS OF SERVICES

9 "SEC. 1816. (a) If any group or association of pro-
10 viders of services wishes to have payments under this part to
11 such providers made through a national, State, or other public
12 or private agency or organization and nominates such agency
13 or organization for this purpose, the Secretary is authorized to
14 enter into an agreement with such agency or organization pro-
15 viding for the determination by such agency or organization
16 (subject to such review by the Secretary as may be pro-
17 vided for by the agreement) of the amount of the payments
18 required pursuant to this part to be made to such providers,
19 and for the making of such payments by such agency or
20 organization to such providers. Such agreement may also
21 include provision for the agency or organization to do all or
22 any part of the following: (1) to provide consultative serv-
23 ices to institutions or agencies to enable them to establish
24 and maintain fiscal records necessary for purposes of this
25 part and otherwise to qualify as hospitals, extended care fa-

1 cilities, or home health agencies, and (2) with respect to the
2 providers of services which are to receive payments through
3 it (A) to serve as a center for, and communicate to pro-
4 viders, any information or instructions furnished to it by the
5 Secretary, and serve as a channel of communication from
6 providers to the Secretary; (B) to make such audits of the
7 records of providers as may be necessary to insure that
8 proper payments are made under this part; and (C) to
9 perform such other functions as are necessary to carry out
10 this subsection.

11 “(b) The Secretary shall not enter into an agreement
12 with any agency or organization under this section unless
13 he finds (1) that to do so is consistent with the effective
14 and efficient administration of this part, (2) that such
15 agency or organization is willing and able to assist the
16 providers to which payments are made through it under
17 this part in the application of safeguards against unnecessary
18 utilization of services furnished by them to individuals en-
19 titled to hospital insurance benefits under section 226, and
20 the agreement provides for such assistance, and (3) such
21 agency or organization agrees to furnish to the Secretary
22 such of the information acquired by it in carrying out its
23 agreement under this section as the Secretary may find
24 necessary in performing his functions under this part.

25 “(c) An agreement with any agency or organization

1 under this section may contain such terms and conditions as
2 the Secretary finds necessary or appropriate, may provide
3 for advances of funds to the agency or organization for the
4 making of payments by it under subsection (a), and shall
5 provide for payment of so much of the cost of administration
6 of the agency or organization as is determined by the Secre-
7 tary to be necessary and proper for carrying out the functions
8 covered by the agreement.

9 “(d) If the nomination of an agency or organization as
10 provided in this section is made by a group or association of
11 providers of services, it shall not be binding on members of
12 the group or association which notify the Secretary of their
13 election to that effect. Any provider may, upon such notice
14 as may be specified in the agreement under this section with
15 an agency or organization, withdraw its nomination to re-
16 ceive payments through such agency or organization. Any
17 provider which has withdrawn its nomination, and any pro-
18 vider which has not made a nomination, may elect to receive
19 payments from any agency or organization which has en-
20 tered into an agreement with the Secretary under this sec-
21 tion if the Secretary and such agency or organization agree
22 to it.

23 “(e) An agreement with the Secretary under this sec-
24 tion may be terminated—

25 “(1) by the agency or organization which entered

1 into such agreement at such time and upon such notice
2 to the Secretary, to the public, and to the providers as
3 may be provided in regulations, or

4 “(2) by the Secretary at such time and upon such
5 notice to the agency or organization, to the providers
6 which have nominated it for purposes of this section,
7 and to the public, as may be provided in regulations,
8 but only if he finds, after reasonable notice and op-
9 portunity for hearing to the agency or organization,
10 that (A) the agency or organization has failed sub-
11 stantially to carry out the agreement, or (B) the con-
12 tinuation of some or all of the functions provided for in
13 the agreement with the agency or organization is dis-
14 advantageous or is inconsistent with the efficient ad-
15 ministration of this part.

16 “(f) An agreement with an agency or organization un-
17 der this section may require any of its officers or employees
18 certifying payments or disbursing funds pursuant to the agree-
19 ment, or otherwise participating in carrying out the agree-
20 ment, to give surety bond to the United States in such
21 amount as the Secretary may deem appropriate.

22 “(g) (1) No individual designated pursuant to an agree-
23 ment under this section as a certifying officer shall, in the
24 absence of gross negligence or intent to defraud the United

1 States, be liable with respect to any payments certified by
2 him under this section.

3 “(2) No disbursing officer shall, in the absence of gross
4 negligence or intent to defraud the United States, be liable
5 with respect to any payment by him under this section if it
6 was based upon a voucher signed by a certifying officer des-
7 ignated as provided in paragraph (1) of this subsection.

8 “FEDERAL HOSPITAL INSURANCE TRUST FUND

9 “SEC. 1817. (a) There is hereby created on the
10 books of the Treasury of the United States a trust fund to be
11 known as the ‘Federal Hospital Insurance Trust Fund’
12 (hereinafter in this section referred to as the ‘Trust Fund’).
13 The Trust Fund shall consist of such amounts as may be
14 deposited in, or appropriated to, such fund as provided in this
15 part. There are hereby appropriated to the Trust Fund for
16 the fiscal year ending June 30, 1966, and for each fiscal
17 year thereafter, out of any moneys in the Treasury not other-
18 wise appropriated, amounts equivalent to 100 per centum
19 of—

20 “(1) the taxes imposed by sections 3101 (b) and
21 3111 (b) of the Internal Revenue Code of 1954 with
22 respect to wages reported to the Secretary of the Treas-
23 ury or his delegate pursuant to subtitle F of such Code
24 after December 31, 1965, as determined by the Secretary
25 of the Treasury by applying the applicable rates of tax

1 under such sections to such wages, which wages shall be
2 certified by the Secretary of Health, Education, and
3 Welfare on the basis of records of wages established and
4 maintained by the Secretary of Health, Education, and
5 Welfare in accordance with such reports; and

6 “(2) the taxes imposed by section 1401 (b) of the
7 Internal Revenue Code of 1954 with respect to self-em-
8 ployment income reported to the Secretary of the Treas-
9 ury or his delegate on tax returns under subtitle F of
10 such Code, as determined by the Secretary of the Treas-
11 ury by applying the applicable rate of tax under such sec-
12 tion to such self-employment income, which self-employ-
13 ment income shall be certified by the Secretary of Health,
14 Education, and Welfare on the basis of records of self-
15 employment established and maintained by the Secre-
16 tary of Health, Education, and Welfare in accordance
17 with such returns.

18 The amounts appropriated by the preceding sentence shall
19 be transferred from time to time from the general fund in
20 the Treasury to the Trust Fund, such amounts to be deter-
21 mined on the basis of estimates by the Secretary of the
22 Treasury of the taxes, specified in the preceding sentence,
23 paid to or deposited into the Treasury; and proper adjust-
24 ments shall be made in amounts subsequently transferred to

1 the extent prior estimates were in excess of or were less than
2 the taxes specified in such sentence.

3 “(b) With respect to the Trust Fund, there is hereby
4 created a body to be known as the Board of Trustees of the
5 Trust Fund (hereinafter in this section referred to as the
6 ‘Board of Trustees’) composed of the Secretary of the
7 Treasury, the Secretary of Labor, and the Secretary of
8 Health, Education, and Welfare, all ex officio. The Secre-
9 tary of the Treasury shall be the Managing Trustee of the
10 Board of Trustees (hereinafter in this section referred to as
11 the ‘Managing Trustee’). The Commissioner of Social
12 Security shall serve as the Secretary of the Board of Trust-
13 ees. The Board of Trustees shall meet not less frequently
14 than once each year. It shall be the duty of the Board of
15 Trustees to—

16 “(1) Hold the Trust Fund;

17 “(2) Report to the Congress not later than the first
18 day of March of each year on the operation and status
19 of the Trust Fund during the preceding fiscal year and
20 on its expected operation and status during the current
21 fiscal year and the next 2 fiscal years;

22 “(3) Report immediately to the Congress whenever
23 the Board is of the opinion that the amount of the Trust
24 Fund is unduly small; and

25 “(4) Review the general policies followed in man-

1 aging the Trust Fund, and recommend changes in such
2 policies, including necessary changes in the provisions
3 of law which govern the way in which the Trust Fund
4 is to be managed.

5 The report provided for in paragraph (2) shall include a
6 statement of the assets of, and the disbursements made from,
7 the Trust Fund during the preceding fiscal year, an estimate
8 of the expected income to, and disbursements to be made
9 from, the Trust Fund during the current fiscal year and
10 each of the next 2 fiscal years, and a statement of the actuarial
11 status of the Trust Fund. Such report shall be printed as a
12 House document of the session of the Congress to which the
13 report is made.

14 “(c) It shall be the duty of the Managing Trustee to
15 invest such portion of the Trust Fund as is not, in his judg-
16 ment, required to meet current withdrawals. Such invest-
17 ments may be made only in interest-bearing obligations of the
18 United States or in obligations guaranteed as to both princi-
19 pal and interest by the United States. For such purpose
20 such obligations may be acquired (1) on original issue at
21 the issue price, or (2) by purchase of outstanding obliga-
22 tions at the market price. The purposes for which obliga-
23 tions of the United States may be issued under the Second
24 Liberty Bond Act, as amended, are hereby extended to
25 authorize the issuance at par of public-debt obligations for

1 purchase by the Trust Fund. Such obligations issued for
2 purchase by the Trust Fund shall have maturities fixed with
3 due regard for the needs of the Trust Fund and shall bear
4 interest at a rate equal to the average market yield (com-
5 puted by the Managing Trustee on the basis of market quota-
6 tions as of the end of the calendar month next preceding the
7 date of such issue) on all marketable interest-bearing obli-
8 gations of the United States then forming a part of the
9 public debt which are not due or callable until after the ex-
10 piration of 4 years from the end of such calendar month;
11 except that where such average market yield is not a
12 multiple of one-eighth of 1 per centum, the rate of interest on
13 such obligations shall be the multiple of one-eighth of 1
14 per centum nearest such market yield. The Managing
15 Trustee may purchase other interest-bearing obligations of the
16 United States or obligations guaranteed as to both principal
17 and interest by the United States, on original issue or at the
18 market price, only where he determines that the purchase
19 of such other obligations is in the public interest.

20 “(d) Any obligations acquired by the Trust Fund (ex-
21 cept public-debt obligations issued exclusively to the Trust
22 Fund) may be sold by the Managing Trustee at the market
23 price, and such public-debt obligations may be redeemed at
24 par plus accrued interest.

1 “(e) The interest on, and the proceeds from the sale or
2 redemption of, any obligations held in the Trust Fund shall
3 be credited to and form a part of the Trust Fund.

4 “(f) (1) The Managing Trustee is directed to pay from
5 time to time from the Trust Fund into the Treasury the
6 amount estimated by him as taxes imposed under section
7 3101 (b) which are subject to refund under section 6413 (c)
8 of the Internal Revenue Code of 1954 with respect to wages
9 paid after December 31, 1965. Such taxes shall be deter-
10 mined on the basis of the records of wages established and
11 maintained by the Secretary of Health, Education, and Wel-
12 fare in accordance with the wages reported to the Secretary
13 of the Treasury or his delegate pursuant to subtitle F of
14 the Internal Revenue Code of 1954, and the Secretary
15 shall furnish the Managing Trustee such information as may
16 be required by the Trustee for such purpose. The payments
17 by the Managing Trustee shall be covered into the Treasury
18 as repayments to the account for refunding internal revenue
19 collections.

20 “(2) Repayments made under paragraph (1) shall
21 not be available for expenditures but shall be carried to
22 the surplus fund of the Treasury. If it subsequently appears

1 that the estimates under such paragraph in any particular
2 period were too high or too low, appropriate adjustments
3 shall be made by the Managing Trustee in future payments.

4 “(g) There shall be transferred periodically (but not
5 less often than once each fiscal year) to the Trust Fund from
6 the Federal Old-Age and Survivors Insurance Trust Fund
7 and from the Federal Disability Insurance Trust Fund
8 amounts equivalent to the amounts not previously so trans-
9 ferred which the Secretary of Health, Education, and
10 Welfare shall have certified as overpayments (other than
11 amounts so certified to the Railroad Retirement Board) pur-
12 suant to section 1870 (b) of this Act. There shall be trans-
13 ferred periodically (but not less often than once each fiscal
14 year) to the Trust Fund from the Railroad Retirement Ac-
15 count amounts equivalent to the amounts not previously so
16 transferred which the Secretary of Health, Education, and
17 Welfare shall have certified as overpayments to the Railroad
18 Retirement Board pursuant to section 1870 (b) of this Act.

19 “(h) The Managing Trustee shall also pay from time to
20 time from the Trust Fund such amounts as the Secretary of
21 Health, Education, and Welfare certifies are necessary to
22 make the payments provided for by this part, and the pay-
23 ments with respect to administrative expenses in accordance
24 with section 201 (g) (1).

1 "PART B—SUPPLEMENTARY HEALTH INSURANCE BENE-
 2 FITS FOR THE AGED

3 "ESTABLISHMENT OF SUPPLEMENTARY HEALTH
 4 INSURANCE PROGRAM FOR THE AGED

5 "SEC. 1831. There is hereby established a voluntary
 6 insurance program to provide health insurance benefits in
 7 accordance with the provisions of this part for individuals 65
 8 years of age or over who elect to enroll under such program,
 9 to be financed from premium payments by enrollees together
 10 with contributions from funds appropriated by the Federal
 11 Government.

12 "SCOPE OF BENEFITS

13 "SEC. 1832. (a) The benefits provided to an individual
 14 by the insurance program established by this part shall con-
 15 sist of—

16 "(1) entitlement to have payment made to him or
 17 on his behalf (subject to the provisions of this part)
 18 for—

19 "(A) physicians' services; and

20 "(B) medical and other health services, except
 21 those described in paragraph (2) (C) ; and

22 "(2) entitlement to have payment made on his be-
 23 half (subject to the provisions of this part) for—

1 “(A) inpatient psychiatric hospital services for
2 up to 60 days during a spell of illness;

3 “(B) home health services for up to 100 visits
4 during a calendar year; and

5 “(C) medical and other health services fur-
6 nished by a provider of services or by others under
7 arrangements with them made by a provider of
8 services.

9 “(b) For definitions of ‘spell of illness’, ‘medical and
10 other health services’, and other terms used in this part, see
11 section 1861.

12 “PAYMENT OF BENEFITS

13 “SEC. 1833. (a) Subject to the succeeding provisions
14 of this section, there shall be paid from the Federal Supple-
15 mentary Health Insurance Benefits Trust Fund, in the
16 case of each individual who is covered under the insurance
17 program established by this part and incurs expenses for
18 services with respect to which benefits are payable under
19 this part, amounts equal to—

20 “(1) in the case of services described in section
21 1832 (a) (1)—80 percent of the reasonable charges
22 for the services; and

23 “(2) in the case of services described in section
24 1832 (a) (2)—80 percent of the reasonable cost of the
25 services (as determined under section 1861 (v)).

1 “(b) Before applying subsection (a) with respect to
2 expenses incurred by an individual during any calendar year,
3 the total amount of the expenses incurred by such individual
4 during such year (which would, except for this subsection,
5 constitute incurred expenses from which benefits payable
6 under subsection (a) are determinable) shall be reduced by
7 a deductible of \$50; except that the amount of the deductible
8 for such calendar year as so determined shall first be reduced
9 by the amount of any expenses incurred by such individual
10 in the last three months of the preceding calendar year and
11 applied toward such individual’s deductible under this sec-
12 tion for such preceding year.

13 “(c) Notwithstanding any other provision of this part,
14 with respect to expenses incurred in any calendar year in
15 connection with the treatment of mental, psychoneurotic,
16 and personality disorders of an individual who is not an
17 inpatient of a hospital at the time such expenses are incurred,
18 there shall be considered as incurred expenses for purposes
19 of subsections (a) and (b) only whichever of the following
20 amounts is the smaller:

21 “(1) \$312.50, or

22 “(2) $62\frac{1}{2}$ percent of such expenses.

23 “(d) Notwithstanding any other provision of this part,
24 expenses for whole blood furnished to an individual in a
25 hospital shall be considered incurred expenses for purposes

1 of subsections (a) and (b) only if he has already been fur-
2 nished in the same spell of illness 3 pints of whole blood for
3 which (except for this subsection or section 1813 (a) (3))
4 payment would be made under this title.

5 “(e) No payment may be made under this part with
6 respect to any services furnished an individual to the extent
7 that such individual is entitled (or would be entitled except
8 for section 1813) to have payment made with respect to such
9 services under part A.

10 “(f) No payment shall be made to any provider of serv-
11 ices or other person under this part unless there has been
12 furnished such information as may be necessary in order to
13 determine the amounts due such provider or other person
14 under this part for the period with respect to which the
15 amounts are being paid or for any prior period.

16 “DURATION OF SERVICES

17 “SEC. 1834. (a) (1) Payment under this part for in-
18 patient psychiatric hospital services furnished an individual
19 during a spell of illness may not be made after such services
20 have been furnished to him for 60 days during such spell;
21 and no payment under this part for inpatient psychiatric
22 hospital services furnished an individual may be made after
23 such services have been furnished to him for a total of 180
24 days during his lifetime.

25 “(2) If an individual is an inpatient in a psychiatric
26 hospital on the first day on which he is entitled to benefits

1 under this part, the days in the 60-day period immediately
2 before such first day on which he was an inpatient in such
3 a hospital shall be included in determining the 60-day limit
4 under paragraph (1) but not in determining the 180-day
5 limit under such paragraph.

6 “(b) Payment under this part may not be made for
7 home health services furnished an individual during any
8 calendar year after such services have been furnished to him
9 during such year for 100 visits. The number of visits to
10 be charged for purposes of the limitation in the preceding
11 sentence, in connection with items and services described in
12 section 1861 (m), shall be determined in accordance with
13 regulations.

14 “(c) For purposes of subsections (a) (1) and (b),
15 inpatient psychiatric hospital services and home health serv-
16 ices shall be taken into account only if payment under this
17 part is or would be, except for this section or the failure to
18 comply with the request and certification requirements of or
19 under section 1835 (a), made with respect to such services.

20 “PROCEDURE FOR PAYMENT OF CLAIMS OF PROVIDERS OF
21 SERVICES

22 “SEC. 1835. (a) Payment for services described in sec-
23 tion 1832 (a) (2) furnished an individual may be made only
24 to providers of services which are eligible therefor under
25 section 1866 (a), and only if—

1 “(1) written request, signed by such individual
2 except in cases in which the Secretary finds it impracti-
3 cable for the individual to do so, is filed for such payment
4 in such form, in such manner, within such time, and by
5 such person or persons as the Secretary may by regula-
6 tions prescribe;

7 “(2) a physician certifies (and recertifies, where
8 such services are furnished over a period of time, in such
9 cases, with such frequency, and accompanied by such
10 supporting material, appropriate to the case involved,
11 as may be provided by regulations, except that the
12 first of such recertifications shall be required in each case
13 of inpatient psychiatric hospital services not later than
14 the 20th day of such period) that—

15 “(A) in the case of inpatient psychiatric hos-
16 pital services, such services are or were required
17 to be given on an inpatient basis, by or under the
18 supervision of a physician, for the psychiatric treat-
19 ment of an individual; and (i) such treatment can
20 or could reasonably be expected to improve the
21 condition for which such treatment is or was neces-
22 sary or (ii) inpatient diagnostic study is or was
23 medically required and such services are or were
24 necessary for such purposes;

25 “(B) in the case of home health services (i)

1 such services are or were required because the indi-
2 vidual is or was confined to his home (except when
3 receiving items and services referred to in section
4 1861 (m) (7)) and needed skilled nursing care on
5 an intermittent basis, or because he needed physical
6 or speech therapy, (ii) a plan for furnishing such
7 services to such individual has been established and is
8 periodically reviewed by a physician, and (iii) such
9 services are or were furnished while the individual
10 is or was under the care of a physician; and

11 “(C) in the case of medical and other health
12 services, such services are or were medically
13 required;

14 “(3) in the case of inpatient psychiatric hospital
15 services, the services are those which the records of the
16 hospital indicate were furnished to the individual during
17 periods when he was receiving (A) intensive treatment
18 services, (B) admission and related services necessary
19 for a diagnostic study, or (C) equivalent services;

20 “(4) with respect to inpatient psychiatric hospital
21 services furnished to the individual after the 20th day
22 of a continuous period of such services, there was not in
23 effect, at the time of admission of such individual to the
24 hospital, a decision under section 1866 (d) (based on a

1 finding that utilization review of long-stay cases is not
2 being made in such hospital) ; and

3 “ (5) with respect to inpatient psychiatric hospital
4 services furnished to the individual during a continuous
5 period, a finding has not been made (by the physician
6 members of the committee or group, as described in
7 section 1861 (k) (4)) pursuant to the system of utiliza-
8 tion review that further inpatient psychiatric hospital
9 services are not medically necessary; except that, if
10 such a finding has been made, payment may be made
11 with respect to such services furnished before the 4th
12 day after the day on which the hospital received notice
13 of such finding.

14 To the extent provided by regulations, the certification and
15 recertification requirements of paragraph (2) shall be
16 deemed satisfied where, at a later date, a physician makes a
17 certification of the kind provided in subparagraph (A),
18 (B), or (C) of paragraph (2) (whichever would have
19 applied), but only where such certification is accom-
20 panied by such medical and other evidence as may be
21 required by such regulations.

22 “ (b) No payment may be made under this part to
23 any Federal provider of services or other Federal agency,
24 except a provider of services which the Secretary determines
25 is providing services to the public generally as a community

1 institution or agency; and no such payment may be made to
2 any provider of services or other person for any item or
3 service which such provider or person is obligated by a law
4 of, or a contract with, the United States to render at public
5 expense.

6 “(c) Notwithstanding that an individual is not entitled
7 to have payment made under this part for inpatient psychi-
8 atric hospital services furnished by any psychiatric hospital,
9 payment shall be made to such hospital (unless it elects not
10 to receive such payment or, if payment has already been
11 made by or on behalf of such individual, fails to refund
12 such payment within the time specified by the Secretary)
13 for such services which are furnished to the individual prior
14 to notification to such hospital from the Secretary of his
15 lack of entitlement, if such payments are precluded only
16 by reason of section 1834 and if such hospital complies
17 with the requirements of and regulations under this title
18 with respect to such payments, has acted in good faith
19 and without knowledge of such lack of entitlement, and has
20 acted reasonably in assuming entitlement existed. Payment
21 under the preceding sentence may not be made for services
22 furnished an individual pursuant to any admission after the
23 6th elapsed day (not including as an elapsed day Saturday,
24 Sunday, or a legal holiday) after the day on which such
25 admission occurred.

1 “ELIGIBLE INDIVIDUALS

2 “SEC. 1836. Every individual who—

3 “(1) has attained the age of 65, and

4 “(2) is a resident of the United States, and is either
5 a citizen or an alien lawfully admitted for permanent
6 residence,

7 is eligible to enroll in the insurance program established
8 by this part.

9 “ENROLLMENT PERIODS

10 “SEC. 1837. (a) An individual may enroll in the in-
11 surance program established by this part only in such man-
12 ner and form as may be prescribed by regulations, and only
13 during an enrollment period prescribed in or under this
14 section.

15 “(b) (1) No individual may enroll for the first time
16 under this part more than 3 years after the close of the first
17 enrollment period during which he could have enrolled under
18 this part.

19 “(2) An individual whose enrollment under this part
20 has terminated may not enroll for the second time under this
21 part unless he does so in a general enrollment period (as
22 provided in subsection (e)) which begins within 3 years
23 after the effective date of such termination. No individual
24 may enroll under this part more than twice.

25 “(c) In the case of individuals who first satisfy para-

1 graphs (1) and (2) of section 1836 before January 1, 1966,
2 the initial general enrollment period shall begin on the first
3 day of the second month which begins after the date of enact-
4 ment of this title and shall end on March 31, 1966.

5 “(d) In the case of an individual who first satisfies
6 paragraphs (1) and (2) of section 1836 on or after Janu-
7 ary 1, 1966, his initial enrollment period shall begin on the
8 first day of the third month before the month in which he
9 first satisfies such paragraphs and shall end seven months
10 later.

11 “(e) There shall be a general enrollment period, after
12 the period described in subsection (c), during the period
13 beginning on October 1 and ending on December 31 of each
14 odd-numbered year beginning with 1967.

15 “COVERAGE PERIOD

16 “SEC. 1838. (a) The period during which an individual
17 is entitled to benefits under the insurance program established
18 by this part (hereinafter referred to as his ‘coverage period’)
19 shall begin on whichever of the following is the latest:

20 “(1) July 1, 1966; or

21 “(2) the first day of the third month following the
22 month in which he enrolls pursuant to subsection (d)
23 of section 1837, or the July 1 following the month in
24 which he enrolls pursuant to subsection (e) of section
25 1837.

1 “(b) An individual’s coverage period shall continue
2 until his enrollment has been terminated—

3 “(1) by the filing of notice, during a general en-
4 rollment period described in section 1837 (e), that the
5 individual no longer wishes to participate in the insur-
6 ance program established by this part, or

7 “(2) for nonpayment of premiums.

8 The termination of a coverage period under paragraph (1)
9 shall take effect at the close of December 31 of the year in
10 which the notice is filed. The termination of a coverage
11 period under paragraph (2) shall take effect on a date de-
12 termined under regulations, which may be determined so
13 as to provide a grace period (not in excess of 90 days) in
14 which overdue premiums may be paid and coverage
15 continued.

16 “(c) No payments may be made under this part with
17 respect to the expenses of an individual unless such expenses
18 were incurred by such individual during a period which,
19 with respect to him, is a coverage period.

20 “AMOUNTS OF PREMIUMS

21 “SEC. 1839. (a) The monthly premium of each in-
22 dividual enrolled under this part for each month before 1968
23 shall be \$3.

24 “(b) (1) The monthly premium of each individual en-

1 rolled under this part for each month after 1967 shall be
2 the amount determined under paragraph (2).

3 “(2) The Secretary shall, between July 1 and Octo-
4 ber 1 of 1967 and of each odd-numbered year thereafter,
5 determine and promulgate the dollar amount which shall be
6 applicable for premiums for months occurring in either of the
7 two succeeding calendar years. Such dollar amount shall be
8 such amount as the Secretary estimates to be necessary so
9 that the aggregate premiums for such two succeeding calen-
10 dar years will equal one-half of the total of the benefits and
11 administrative costs which he estimates will be payable from
12 the Federal Supplementary Health Insurance Benefits Trust
13 Fund for such two succeeding calendar years. In estimating
14 aggregate benefits payable for any period, the Secretary shall
15 include an appropriate amount for a contingency margin.

16 “(c) In the case of an individual whose coverage period
17 began pursuant to an enrollment after his initial enrollment
18 period (determined pursuant to subsection (c) or (d) of
19 section 1837), the monthly premium determined under sub-
20 section (b) shall be increased by 10 percent of the monthly
21 premium so determined for each full 12 months in which
22 he could have been but was not enrolled. For purposes of
23 the preceding sentence, there shall be taken into account
24 (1) the months which elapsed between the close of his

1 initial enrollment period and the close of the enrollment
2 period in which he enrolled, plus (in the case of an individual
3 who enrolls for a second time) (2) the months which
4 elapsed between the date of the termination of his first
5 coverage period and the close of the enrollment period in
6 which he enrolled for the second time.

7 “(d) If any monthly premium determined under the
8 foregoing provisions of this section is not a multiple of 10
9 cents, such premium shall be rounded to the nearest multiple
10 of 10 cents.

11 “PAYMENT OF PREMIUMS

12 “SEC. 1840. (a) (1) In the case of an individual who
13 is entitled to monthly benefits under section 202, his monthly
14 premiums under this part shall (except as provided in sub-
15 section (d)) be collected by deducting the amount thereof
16 from the amount of such monthly benefits. Such deduction
17 shall be made in such manner and at such times as the Sec-
18 retary shall by regulation prescribe.

19 “(2) The Secretary of the Treasury shall, from time
20 to time, transfer from the Federal Old-Age and Survivors
21 Insurance Trust Fund or the Federal Disability Insurance
22 Trust Fund to the Federal Supplementary Health Insurance
23 Benefits Trust Fund the aggregate amount deducted under
24 paragraph (1) for the period to which such transfer relates
25 from benefits under section 202 which are payable from

1 such Trust Fund. Such transfer shall be made on the basis
2 of a certification by the Secretary of Health, Education,
3 and Welfare and shall be appropriately adjusted to the
4 extent that prior transfers were too great or too small.

5 “(b) (1) In the case of an individual who is entitled
6 to receive for a month an annuity or pension under the
7 Railroad Retirement Act of 1937, his monthly premiums
8 under this part shall (except as provided in subsection (d))
9 be collected by deducting the amount thereof from such an-
10 nuity or pension. Such deduction shall be made in such man-
11 ner and at such times as the Secretary shall by regulations
12 prescribe. Such regulations shall be prescribed only after
13 consultation with the Railroad Retirement Board.

14 “(2) The Secretary of the Treasury shall, from time to
15 time, transfer from the Railroad Retirement Account to the
16 Federal Supplementary Health Insurance Benefits Trust
17 Fund the aggregate amount deducted under paragraph (1)
18 for the period to which such transfer relates. Such transfers
19 shall be made on the basis of a certification by the Railroad
20 Retirement Board and shall be appropriately adjusted to the
21 extent that prior transfers were too great or too small.

22 “(c) In the case of an individual who is entitled both
23 to monthly benefits under section 202 and to an annuity or
24 pension under the Railroad Retirement Act of 1937 at the
25 time he enrolls under this part, subsection (a) shall apply

1 so long as he continues to be entitled both to such benefits
2 and such annuity or pension. In the case of an individual
3 who becomes entitled both to such benefits and such an
4 annuity or pension after he enrolls under this part, subsection
5 (a) shall apply if the first month for which he was entitled
6 to such benefits was the same as or earlier than the first
7 month for which he was entitled to such annuity or pension,
8 and otherwise subsection (b) shall apply.

9 “(d) If an individual to whom subsection (a) or (b)
10 applies estimates that the amount which will be available
11 for deduction under such subsection for any premium pay-
12 ment period will be less than the amount of the monthly
13 premiums for such period, he may (under regulations) pay
14 to the Secretary such portion of the monthly premiums for
15 such period as he desires.

16 “(e) In the case of an individual who participates in
17 the insurance program established by this part but with re-
18 spect to whom neither subsection (a) nor subsection (b)
19 applies, the premiums shall be paid to the Secretary at such
20 times, and in such manner, as the Secretary shall by regula-
21 tions prescribe.

22 “(f) Amounts paid to the Secretary under subsection
23 (d) or (e) shall be deposited in the Treasury to the credit
24 of the Federal Supplementary Health Insurance Benefits
25 Trust Fund.

1 “(g) In the case of an individual who participates in
2 the insurance program established by this part, premiums
3 shall be payable for the period commencing with the first
4 month of his coverage period and ending with the month
5 in which he dies or, if earlier, in which his coverage under
6 such program terminates.

7 "FEDERAL SUPPLEMENTARY HEALTH INSURANCE BENE-
8 FITS TRUST FUND

9 “SEC. 1841. (a) There is hereby created on the books of
10 the Treasury of the United States a trust fund to be known
11 as the ‘Federal Supplementary Health Insurance Benefits
12 Trust Fund’ (hereinafter in this section referred to as the
13 ‘Trust Fund’). The Trust Fund shall consist of such amounts
14 as may be deposited in, or appropriated to, such fund as
15 provided in this part.

16 “(b) With respect to the Trust Fund, there is hereby
17 created a body to be known as the Board of Trustees of the
18 Trust Fund (hereinafter in this section referred to as the
19 ‘Board of Trustees’) composed of the Secretary of the
20 Treasury, the Secretary of Labor, and the Secretary of
21 Health, Education, and Welfare, all ex officio. The Secre-
22 tary of the Treasury shall be the Managing Trustee of the
23 Board of Trustees (hereinafter in this section referred to as
24 the ‘Managing Trustee’). The Commissioner of Social

1 Security shall serve as the Secretary of the Board of Trust-
2 ees. The Board of Trustees shall meet not less frequently
3 than once each year. It shall be the duty of the Board of
4 Trustees to—

5 “(1) Hold the Trust Fund;

6 “(2) Report to the Congress not later than the first
7 day of March of each year on the operation and status
8 of the Trust Fund during the preceding fiscal year and
9 on its expected operation and status during the current
10 fiscal year and the next 2 fiscal years;

11 “(3) Report immediately to the Congress whenever
12 the Board is of the opinion that the amount of the Trust
13 Fund is unduly small; and

14 “(4) Review the general policies followed in man-
15 aging the Trust Fund, and recommend changes in such
16 policies, including necessary changes in the provisions
17 of law which govern the way in which the Trust Fund
18 is to be managed.

19 The report provided for in paragraph (2) shall include a
20 statement of the assets of, and the disbursements made from,
21 the Trust Fund during the preceding fiscal year, an estimate
22 of the expected income to, and disbursements to be made
23 from, the Trust Fund during the current fiscal year and each
24 of the next 2 fiscal years, and a statement of the actuarial
25 status of the Trust Fund. Such report shall be printed as a

1 House document of the session of the Congress to which the
2 report is made.

3 “(c) It shall be the duty of the Managing Trustee to
4 invest such portion of the Trust Fund as is not, in his judg-
5 ment, required to meet current withdrawals. Such invest-
6 ments may be made only in interest-bearing obligations of the
7 United States or in obligations guaranteed as to both princi-
8 pal and interest by the United States. For such purpose
9 such obligations may be acquired (1) on original issue at
10 the issue price, or (2) by purchase of outstanding obliga-
11 tions at the market price. The purposes for which obliga-
12 tions of the United States may be issued under the Second
13 Liberty Bond Act, as amended, are hereby extended to
14 authorize the issuance at par of public-debt obligations for
15 purchase by the Trust Fund. Such obligations issued for
16 purchase by the Trust Fund shall have maturities fixed with
17 due regard for the needs of the Trust Fund and shall bear
18 interest at a rate equal to the average market yield (com-
19 puted by the Managing Trustee on the basis of market quota-
20 tions as of the end of the calendar month next preceding the
21 date of such issue) on all marketable interest-bearing obli-
22 gations of the United States then forming a part of the
23 public debt which are not due or callable until after the ex-
24 piration of 4 years from the end of such calendar month;
25 except that where such average market yield is not a multi-

1 ple of one-eighth of 1 per centum, the rate of interest on
2 such obligations shall be the multiple of one-eighth of 1
3 per centum nearest such market yield. The Managing
4 Trustee may purchase other interest-bearing obligations of the
5 United States or obligations guaranteed as to both principal
6 and interest by the United States, on original issue or at the
7 market price, only where he determines that the purchase
8 of such other obligations is in the public interest.

9 “(d) Any obligations acquired by the Trust Fund (ex-
10 cept public-debt obligations issued exclusively to the Trust
11 Fund) may be sold by the Managing Trustee at the market
12 price, and such public-debt obligations may be redeemed at
13 par plus accrued interest.

14 “(e) The interest on, and the proceeds from the sale
15 or redemption of, any obligations held in the Trust Fund
16 shall be credited to and form a part of the Trust Fund.

17 “(f) There shall be transferred periodically (but not
18 less often than once each fiscal year) to the Trust Fund
19 from the Federal Old-Age and Survivors Insurance Trust
20 Fund and from the Federal Disability Insurance Trust Fund
21 amounts equivalent to the amounts not previously so trans-
22 ferred which the Secretary of Health, Education, and Wel-
23 fare shall have certified as overpayments (other than
24 amounts so certified to the Railroad Retirement Board) pur-
25 suant to section 1870 (b) of this Act. There shall be trans-

1 ferred periodically (but not less often than once each fiscal
2 year) to the Trust Fund from the Railroad Retirement
3 Account amounts equivalent to the amounts not previously
4 so transferred which the Secretary of Health, Education, and
5 Welfare shall have certified as overpayments to the Railroad
6 Retirement Board pursuant to section 1870 (b) of this Act.

7 “(g) The Managing Trustee shall pay from time to
8 time from the Trust Fund such amounts as the Secretary of
9 Health, Education, and Welfare certifies are necessary to
10 make the payments provided for by this part, and the pay-
11 ments with respect to administrative expenses in accordance
12 with section 201 (g) (1).

13 “USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

14 “SEC. 1842. (a) In order to provide for the adminis-
15 tration of the benefits under this part, the Secretary shall
16 to the extent possible enter into contracts with carriers which
17 will undertake to perform the following functions or, to the
18 extent provided in such contracts, to secure such performance
19 by other organizations:

20 “(1) (A) make determinations of the rates and
21 amounts of payments required pursuant to this part to
22 be made to providers of services and other persons on
23 a reasonable cost or reasonable charge basis (as may
24 be applicable) ;

1 “(B) receive, disburse, and account for funds in
2 making such payments; and

3 “(C) make such audits of the records of providers
4 of services as may be necessary to assure that proper
5 payments are made under this part;

6 “(2) (A) determine compliance with the require-
7 ments of section 1861 (k) as to utilization review; and

8 “(B) assist providers of services and other persons
9 who furnish services for which payment may be made
10 under this part in the development of procedures relating
11 to utilization practices, make studies of the effectiveness
12 of such procedures and methods for their improvement,
13 assist in the application of safeguards against unneces-
14 sary utilization of services furnished by providers of
15 services and other persons to individuals entitled to bene-
16 fits under this part, and provide procedures for and assist
17 in arranging, where necessary, the establishment of
18 groups outside hospitals (meeting the requirements of
19 section 1861 (k) (2)) to make reviews of utilization;

20 “(3) serve as a channel of communication of infor-
21 mation relating to the administration of this part; and

22 “(4) otherwise assist, in such manner as the con-
23 tract may provide, in discharging administrative duties
24 necessary to carry out the purposes of this part.

25 “(b) (1) Contracts with carriers under subsection (a)

1 may be entered into without regard to section 3709 of the
2 Revised Statutes or any other provision of law requiring
3 competitive bidding.

4 “(2) No such contract shall be entered into with any
5 carrier unless the Secretary finds that such carrier will
6 perform its obligations under the contract efficiently and
7 effectively and will meet such requirements as to financial
8 responsibility, legal authority, and other matters as he finds
9 pertinent.

10 “(3) Each such contract shall provide that the carrier—

11 “(A) will take such action as may be necessary to
12 assure that, where payment under this part for a service
13 is on a cost basis, the cost is reasonable cost (as deter-
14 mined under section 1861 (v)) ;

15 “(B) will take such action as may be necessary to
16 assure that, where payment under this part for a service
17 is on a charge basis, (i) such charge will be reasonable
18 and not higher than the charge applicable, for a com-
19 parable service and under comparable circumstances, to
20 the policyholders and subscribers of the carrier, and
21 (ii) such payment will be made on the basis of a re-
22 ceipted bill, or on the basis of an assignment under the
23 terms of which the reasonable charge is the full charge
24 for the service;

25 “(C) will establish and maintain procedures pur-

1 suant to which an individual enrolled under this part
2 will be granted an opportunity for a fair hearing by the
3 carrier when requests for payment under this part with
4 respect to services furnished him are denied or are not
5 acted upon with reasonable promptness or when the
6 amount of such payment is in controversy;

7 “(D) will furnish to the Secretary such timely
8 information and reports as he may find necessary in
9 performing his functions under this part; and

10 “(E) will maintain such records and afford such
11 access thereto as the Secretary finds necessary to assure
12 the correctness and verification of the information and
13 reports under subparagraph (D) and otherwise to carry
14 out the purposes of this part;

15 and shall contain such other terms and conditions not incon-
16 sistent with this section as the Secretary may find necessary
17 or appropriate.

18 “(4) Each contract under this section shall be for a
19 term of at least one year, and may be made automatically
20 renewable from term to term in the absence of notice by
21 either party of intention to terminate at the end of the cur-
22 rent term; except that the Secretary may terminate any
23 such contract at any time (after such reasonable notice and
24 opportunity for hearing to the carrier involved as he may
25 provide in regulations) if he finds that the carrier has failed
26 substantially to carry out the contract or is carrying out the

1 contract in a manner inconsistent with the efficient and
2 effective administration of the insurance program established
3 by this part.

4 “(c) Any contract entered into with a carrier under
5 this section shall provide for advances of funds to the carrier
6 for the making of payments by it under this part, and shall
7 provide for payment of the cost of administration of the
8 carrier, as determined by the Secretary to be necessary and
9 proper for carrying out the functions covered by the contract.

10 “(d) Any contract with a carrier under this section may
11 require such carrier or any of its officers or employees certify-
12 ing payments or disbursing funds pursuant to the contract,
13 or otherwise participating in carrying out the contract, to
14 give surety bond to the United States in such amount as the
15 Secretary may deem appropriate.

16 “(e) (1) No individual designated pursuant to a con-
17 tract under this section as a certifying officer shall, in the
18 absence of gross negligence or intent to defraud the United
19 States, be liable with respect to any payments certified by
20 him under this section.

21 “(2) No disbursing officer shall, in the absence of gross
22 negligence or intent to defraud the United States, be liable
23 with respect to any payment by him under this section if
24 it was based upon a voucher signed by a certifying officer
25 designated as provided in paragraph (1) of this subsection.

1 “(f) For purposes of this part, the term ‘carrier’
2 means—

3 “(1) with respect to providers of services and other
4 persons, a voluntary association, corporation, partner-
5 ship, or other nongovernmental organization which is
6 lawfully engaged in providing, paying for, or reimburs-
7 ing the cost of, health services under group insurance
8 policies or contracts, medical or hospital service agree-
9 ments, membership or subscription contracts, or similar
10 group arrangements, in consideration of premiums or
11 other periodic charges payable to the carrier, including
12 a health benefits plan duly sponsored or underwritten by
13 an employee organization; and

14 “(2) with respect to providers of services only, any
15 agency or organization (not described in paragraph
16 (1)) with which an agreement is in effect under section
17 1816.

18 “STATE AGREEMENTS FOR COVERAGE OF ELIGIBLE INDIVID-
19 UALS WHO ARE RECEIVING MONEY PAYMENTS UNDER
20 PUBLIC ASSISTANCE PROGRAMS

21 “SEC. 1843. (a) The Secretary shall, at the request of
22 a State made before July 1, 1967, enter into an agreement
23 with such State pursuant to which all eligible individuals
24 in either of the coverage groups described in subsection (b)
25 (as specified in the agreement) will be enrolled under the
26 program established by this part.

1 “(b) An agreement entered into with any State pur-
2 suant to subsection (a) may be applicable to either of the
3 following coverage groups:

4 “(1) individuals receiving money payments under
5 the plan of such State approved under title I or title
6 XVI; or .

7 “(2) individuals receiving money payments under
8 all of the plans of such State approved under titles I,
9 IV, X, XIV, and XVI;

10 except that there shall be excluded from any coverage group
11 any individual who is entitled to monthly insurance benefits
12 under title II or who is entitled to receive an annuity or
13 pension under the Railroad Retirement Act of 1937.

14 “(c) For purposes of this section, an individual shall
15 be treated as an eligible individual only if he is an eligible
16 individual (within the meaning of section 1836) on the date
17 an agreement covering him is entered into under subsection
18 (a) or he becomes an eligible individual (within the mean-
19 ing of such section) at any time after such date and before
20 July 1, 1967; and he shall be treated as receiving money
21 payments described in subsection (b) if he receives such
22 payments for the month in which the agreement is entered
23 into or any month thereafter before July 1967.

24 “(d) In the case of any individual enrolled pursuant to
25 this section—

1 “(1) the monthly premium to be paid by the State
2 shall be determined under section 1839 (without any in-
3 crease under subsection (c) thereof) ;

4 “(2) his coverage period shall begin on whichever
5 of the following is the latest :

6 “(A) July 1, 1966;

7 “(B) the first day of the third month following
8 the month in which the State agreement is entered
9 into;

10 “(C) the first day of the first month in which
11 he is both an eligible individual and a member of a
12 coverage group specified in the agreement under
13 this section; or

14 “(D) such date (not later than July 1, 1967)
15 as may be specified in the agreement; and

16 “(3) his coverage period attributable to the agree-
17 ment with the State under this section shall end on the
18 last day of whichever of the following first occurs:

19 “(A) the month in which he is determined by
20 the State agency to have become ineligible for
21 money payments of a kind specified in the agree-
22 ment, or

23 “(B) the month preceding the first month for

1 which he becomes entitled to monthly benefits under
2 title II or to an annuity or pension under the Rail-
3 road Retirement Act of 1937.

4 “(e) Any individual whose coverage period attributable
5 to the State agreement is terminated pursuant to subsection
6 (d) (3) shall be deemed for purposes of this part (including
7 the continuation of his coverage period under this part) to
8 have enrolled under section 1837 in the initial general en-
9 rollment period provided by section 1837 (c).

10 “(f) With respect to eligible individuals receiving
11 money payments under the plan of a State approved under
12 title I, IV, X, XIV, or XVI, if the agreement entered
13 into under this section so provides, the term ‘carrier’ as
14 defined in section 1842 (f) also includes the State agency,
15 specified in such agreement, which administers or super-
16 vises the administration of the plan of such State approved
17 under title I, XVI, or XIX. The agreement shall also
18 contain such provisions as will facilitate the financial trans-
19 actions of the State and the carrier with respect to deduc-
20 tions, coinsurance, and otherwise, and as will lead to econ-
21 omy and efficiency of operation, with respect to individuals
22 receiving money payments under plans of the State ap-
23 proved under titles I, IV, X, XIV, and XVI.

1 "APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS
2 AND CONTINGENCY RESERVE

3 "SEC. 1844. (a) There are authorized to be appro-
4 priated from time to time, out of any moneys in the Treasury
5 not otherwise appropriated, to the Federal Supplementary
6 Health Insurance Benefits Trust Fund, a Government con-
7 tribution equal to the aggregate premiums payable under
8 this part.

9 "(b) In order to assure prompt payment of benefits
10 provided under this part and the administrative expenses
11 thereunder during the early months of the program estab-
12 lished by this part, and to provide a contingency reserve,
13 there is also authorized to be appropriated during the
14 fiscal year ending June 30, 1966, out of any moneys in
15 the Treasury not otherwise appropriated, to remain available
16 through the next fiscal year for repayable advances (without
17 interest) to the Trust Fund, an amount equal to \$18 multi-
18 plied by the number of individuals (as estimated by the
19 Secretary) who could be covered in July 1966 by the insur-
20 ance program established by this part if they had theretofore
21 enrolled under this part.

22 "PART C—MISCELLANEOUS PROVISIONS

23 "DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

24 "SEC. 1861. For purposes of this title—

1 “Spell of Illness

2 “(a) The term ‘spell of illness’ with respect to any
3 individual means a period of consecutive days—

4 “(1) beginning with the first day (not included
5 in a previous spell of illness) (A) on which such
6 individual is furnished inpatient hospital services or
7 extended care services, and (B) which occurs in a
8 month for which he is entitled to benefits under part
9 A or part B, and

10 “(2) ending with the close of the first period
11 of 60 consecutive days thereafter on each of which
12 he is neither an inpatient of a hospital nor an in-
13 patient of an extended care facility.

14 “Inpatient Hospital Services

15 “(b) The term ‘inpatient hospital services’ means the
16 following items and services furnished to an inpatient of a
17 hospital and (except as provided in paragraph (3)) by
18 the hospital—

19 “(1) bed and board;

20 “(2) such nursing services and other related serv-
21 ices, such use of hospital facilities, and such medical
22 social services as are ordinarily furnished by the hospi-
23 tal for the care and treatment of inpatients, and such

1 drugs, biologicals, supplies, appliances, and equipment,
 2 for use in the hospital, as are ordinarily furnished by
 3 such hospital for the care and treatment of inpatients;
 4 and

5 “(3) such other diagnostic or therapeutic items or
 6 services, furnished by the hospital or by others under
 7 arrangements with them made by the hospital, as are
 8 ordinarily furnished to inpatients either by such hos-
 9 pital or by others under such arrangements;

10 excluding, however—

11 “(4) medical or surgical services provided by a
 12 physician, resident, or intern; and

13 “(5) the services of a private-duty nurse or other
 14 private-duty attendant.

15 Paragraph (4) shall not apply to services provided in the
 16 hospital by an intern or a resident-in-training under a teach-
 17 ing program approved by the Council on Medical Education
 18 of the American Medical Association (or, in the case of an
 19 osteopathic hospital, approved by the Committee on Hospi-
 20 tals of the Bureau of Professional Education of the American
 21 Osteopathic Association).

22 “Inpatient Psychiatric Hospital Services

23 “(c) The term ‘inpatient psychiatric hospital services’
 24 means inpatient hospital services furnished to an inpatient
 25 of a psychiatric hospital.

1 “Inpatient Tuberculosis Hospital Services

2 “(d) The term ‘inpatient tuberculosis hospital services’
3 means inpatient hospital services furnished to an inpatient
4 of a tuberculosis hospital.

5 “Hospital

6 “(e) The term ‘hospital’ (except for purposes of sec-
7 tion 1814 (d), subsection (a) (2) of this section, paragraph
8 (7) of this subsection, and subsections (i) and (n) of this
9 section) means an institution which—

10 “(1) is primarily engaged in providing, by or
11 under the supervision of physicians, to inpatients (A)
12 diagnostic services and therapeutic services for medical
13 diagnosis, treatment, and care of injured, disabled, or
14 sick persons, or (B) rehabilitation services for the re-
15 habilitation of injured, disabled, or sick persons;

16 “(2) maintains clinical records on all patients;

17 “(3) has bylaws in effect with respect to its staff
18 of physicians;

19 “(4) has a requirement that every patient must
20 be under the care of a physician;

21 “(5) provides 24-hour nursing service rendered
22 or supervised by a registered professional nurse, and has
23 a licensed practical nurse or registered professional nurse
24 on duty at all times;

1 “(6) has in effect a hospital utilization review plan
2 which meets the requirements of subsection (k) ;

3 “(7) in the case of an institution in any State in
4 which State or applicable local law provides for the
5 licensing of hospitals, (A) is licensed pursuant to such
6 law or (B) is approved, by the agency of such State
7 or locality responsible for licensing hospitals, as meeting
8 the standards established for such licensing; and

9 “(8) meets such other requirements as the Sec-
10 retary finds necessary in the interest of the health and
11 safety of individuals who are furnished services in the
12 institution, except that such other requirements may not
13 be higher than the comparable requirements prescribed
14 for the accreditation of hospitals by the Joint Commis-
15 sion on the Accreditation of Hospitals.

16 For purposes of subsection (a) (2), such term includes
17 any institution which meets the requirements of paragraph
18 (1) of this subsection. For purposes of sections 1814 (d)
19 (including determination of whether an individual received
20 inpatient hospital services for purposes of such section), and
21 subsections (i) and (n) of this section, such term in-
22 cludes any institution which meets the requirements of para-
23 graphs (1), (2), (3), (4), (5), and (7) of this subsec-
24 tion. Notwithstanding the preceding provisions of this sub-
25 section, such term shall not, except for purposes of subsection

1 (a) (2), include any institution which is primarily for the
 2 care and treatment of mental diseases or tuberculosis; except
 3 that for purposes of part A (and so much of this part as
 4 relates to part A) such term shall include such an institu-
 5 tion if it is a tuberculosis hospital (as defined in subsection
 6 (g)), and for purposes of part B (and so much of this part as
 7 relates to part B) such term shall include such an institution
 8 if it is a psychiatric hospital (as defined in subsection (f)).
 9 The term 'hospital' also includes a Christian Science sana-
 10 torium operated, or listed and certified, by the First Church
 11 of Christ Scientist, Boston, Massachusetts, but only with
 12 respect to items and services ordinarily furnished by such
 13 institution to inpatients, and payment may be made with
 14 respect to services provided by or in such an institution
 15 only to the extent and under such conditions, limitations,
 16 and requirements (in addition to or in lieu of the conditions,
 17 limitations, and requirements otherwise applicable) as may
 18 be provided in regulations. For provisions deeming certain
 19 requirements of this subsection to be met in the case of
 20 accredited institutions, see section 1865.

21 "Psychiatric Hospital

22 " (f) The term 'psychiatric hospital' means an institu-
 23 tion which—

24 " (1) is primarily engaged in providing, by or un-

1 der the supervision of a physician, psychiatric services
2 for the diagnosis and treatment of mentally ill persons;

3 “(2) satisfies the requirements of paragraphs (3)
4 through (8) of subsection (e) ;

5 “(3) maintains clinical records on all patients and
6 maintains such records as the Secretary finds to be neces-
7 sary to determine the degree and intensity of the treat-
8 ment provided to individuals enrolled under the insurance
9 program established by part B;

10 “(4) meets such staffing requirements as the Sec-
11 retary finds necessary for the institution to carry out an
12 active program of treatment for individuals who are fur-
13 nished services in the institution ; and

14 “(5) is accredited by the Joint Commission on the
15 Accreditation of Hospitals.

16 In the case of an institution which satisfies paragraphs (1)
17 and (2) of the preceding sentence and which contains a
18 distinct part which also satisfies paragraphs (3) and (4) of
19 such sentence, such distinct part shall be considered to be a
20 ‘psychiatric hospital’ if the institution is accredited by the
21 Joint Commission on the Accreditation of Hospitals or if such
22 distinct part meets requirements equivalent to such accredita-
23 tion requirements as determined by the Secretary.

1 “Tuberculosis Hospital

2 “(g) The term ‘tuberculosis hospital’ means an institu-
3 tion which—

4 “(1) is primarily engaged in providing, by or under
5 the supervision of a physician, medical services for the
6 diagnosis and treatment of tuberculosis;

7 “(2) satisfies the requirements of paragraphs (3)
8 through (8) of subsection (e) ;

9 “(3) maintains clinical records on all patients and
10 maintains such records as the Secretary finds to be neces-
11 sary to determine the degree and intensity of the treat-
12 ment provided to individuals covered by the insurance
13 program established by part A ;

14 “(4) meets such staffing requirements as the Secre-
15 tary finds necessary for the institution to carry out an
16 active program of treatment for individuals who are
17 furnished services in the institution; and

18 “(5) is accredited by the Joint Commission on the
19 Accreditation of Hospitals.

20 In the case of an institution which satisfies paragraphs (1)
21 and (2) of the preceding sentence and which contains a
22 distinct part which also satisfies paragraphs (3) and (4) of
23 such sentence, such distinct part shall be considered to be a

1 'tuberculosis hospital' if the institution is accredited by the
2 Joint Commission on the Accreditation of Hospitals or if
3 such distinct part meets requirements equivalent to such
4 accreditation requirements as determined by the Secretary.

5 "Extended Care Services

6 "(h) The term 'extended care services' means the fol-
7 lowing items and services furnished to an inpatient of an
8 extended care facility and (except as provided in paragraphs
9 (3) and (6)) by such extended care facility—

10 "(1) nursing care provided by or under the super-
11 vision of a registered professional nurse;

12 "(2) bed and board in connection with the fur-
13 nishing of such nursing care;

14 "(3) physical, occupational, or speech therapy
15 furnished by the extended care facility or by others
16 under arrangements with them made by the facility;

17 "(4) medical social services;

18 "(5) such drugs, biologicals, supplies, appliances,
19 and equipment, furnished for use in the extended care
20 facility, as are ordinarily furnished by such facility for
21 the care and treatment of inpatients;

22 "(6) medical services provided by an intern or resi-
23 dent-in-training of a hospital with which the facility has
24 in effect a transfer agreement (meeting the requirements
25 of subsection (1)), under a teaching program of such

1 hospital approved as provided in the last sentence of
2 subsection (b), and other diagnostic or therapeutic
3 services provided by a hospital with which the facility
4 has such an agreement in effect; and

5 “(7) such other services necessary to the health
6 of the patients as are generally provided by extended
7 care facilities;

8 excluding, however, any item or service if it would not be
9 included under subsection (b) if furnished to an inpatient
10 of a hospital.

11 “Post-Hospital Extended Care Services

12 “(i) The term ‘post-hospital extended care services’
13 means extended care services furnished an individual after
14 transfer from a hospital in which he was an inpatient for not
15 less than 3 consecutive days before his discharge from the
16 hospital in connection with such transfer. For purposes of
17 the preceding sentence, items and services shall be deemed
18 to have been furnished to an individual after transfer from a
19 hospital, and he shall be deemed to have been an inpatient
20 in the hospital immediately before transfer therefrom, if
21 he is admitted to the extended care facility within 14
22 days after discharge from such hospital, and such individual
23 shall be deemed not to have been discharged from the
24 extended care facility if readmitted thereto within 14 days
25 after discharge therefrom.

1 “Extended Care Facility

2 “(j) The term ‘extended care facility’ means (except
3 for purposes of subsection (a) (2)) an institution (or a
4 distinct part of an institution) which has in effect a transfer
5 agreement (meeting the requirements of subsection (1))
6 with one or more hospitals having agreements in effect
7 under section 1866 and which—

8 “(1) is primarily engaged in providing to in-
9 patients (A) skilled nursing care and related services
10 for patients who require medical or nursing care, or (B)
11 rehabilitation services for the rehabilitation of injured,
12 disabled, or sick persons;

13 “(2) has policies, which are developed with the
14 advice of (and with provision of review of such policies
15 from time to time by) a group of professional personnel,
16 including one or more physicians and one or more regis-
17 tered professional nurses, to govern the skilled nursing
18 care and related medical or other services it provides;

19 “(3) has a physician, a registered professional
20 nurse, or a medical staff responsible for the execution
21 of such policies;

22 “(4) (A) has a requirement that the health care of
23 every patient must be under the supervision of a physi-
24 cian, and (B) provides for having a physician available
25 to furnish necessary medical care in case of emergency;

1 “(5) maintains clinical records on all patients;

2 “(6) provides 24-hour nursing service which is
3 sufficient to meet nursing needs in accordance with the
4 policies developed as provided in paragraph (2), and
5 has at least one registered professional nurse employed
6 full time;

7 “(7) provides appropriate methods and procedures
8 for the dispensing and administering of drugs and
9 biologicals;

10 “(8) has in effect a utilization review plan which
11 meets the requirements of subsection (k) ;

12 “(9) in the case of an institution in any State in
13 which State or applicable local law provides for the
14 licensing of institutions of this nature, (A) is licensed
15 pursuant to such law, or (B) is approved, by the agency
16 of such State or locality responsible for licensing institu-
17 tions of this nature, as meeting the standards estab-
18 lished for such licensing; and

19 “(10) meets such other conditions relating to the
20 health and safety of individuals who are furnished serv-
21 ices in such institution or relating to the physical facili-
22 ties thereof as the Secretary may find necessary;

23 except that such term shall not (other than for purposes of
24 subsection (a) (2)) include any institution which is pri-
25 marily for the care and treatment of mental diseases or tuber-

1 culosis. For purposes of subsection (a) (2), such term
2 includes any institution which meets the requirements of
3 paragraph (1) of this subsection.

4 "Utilization Review

5 " (k) A utilization review plan of a hospital or extended
6 care facility shall be considered sufficient if it is applicable
7 to services furnished by the institution to individuals entitled
8 to insurance benefits under this title and if it provides—

9 " (1) for the review, on a sample or other basis,
10 of admissions to the institution, the duration of stays
11 therein, and the professional services (including drugs
12 and biologicals) furnished, (A) with respect to the
13 medical necessity of the services, and (B) for the pur-
14 pose of promoting the most efficient use of available
15 health facilities and services;

16 " (2) for such review to be made by either (A)
17 a staff committee of the institution composed of two
18 or more physicians, with or without participation of
19 other professional personnel, or (B) a group outside the
20 institution which is similarly composed and (i) which
21 is established by the local medical society and some or
22 all of the hospitals and extended care facilities in the
23 locality, or (ii) if (and for as long as) there has not
24 been established such a group which serves such insti-
25 tution, which is established in such other manner as
26 may be approved by the Secretary;

1 “(3) for such review, in each case of inpatient
2 hospital services or extended care services furnished to
3 such an individual during a continuous period of ex-
4 tended duration, as of such days of such period (which
5 may differ for different classes of cases) as may be speci-
6 fied in regulations, with such review to be made as
7 promptly as possible, after each day so specified, and
8 in no event later than one week following such day;
9 and

10 “(4) for prompt notification to the institution, the
11 individual, and his attending physician of any finding
12 (made after opportunity for consultation to such attend-
13 ing physician) by the physician members of such com-
14 mittee or group that any further stay in the institution
15 is not medically necessary.

16 The review committee must be composed as provided in
17 clause (B) of paragraph (2) rather than as provided in
18 clause (A) of such paragraph in the case of any hospital
19 or extended care facility where, because of the small size of
20 the institution, or (in the case of an extended care facility)
21 because of lack of an organized medical staff, or for such
22 other reason or reasons as may be included in regulations,
23 it is impracticable for the institution to have a properly
24 functioning staff committee for the purposes of this sub-
25 section.

“Agreements for Transfer Between Extended Care Facilities and Hospitals

“(1) A hospital and an extended care facility shall be considered to have a transfer agreement in effect if, by reason of a written agreement between them or (in case the two institutions are under common control) by reason of a written undertaking by the person or body which controls them, there is reasonable assurance that—

“(1) transfer of patients will be effected between the hospital and the extended care facility whenever such transfer is medically appropriate as determined by the attending physician; and

“(2) there will be interchange of medical and other information necessary or useful in the care and treatment of individuals transferred between the institutions, or in determining whether such individuals can be adequately cared for otherwise than in either of such institutions.

Any extended care facility which does not have such an agreement in effect, but which is found by a State agency (of the State in which such facility is situated) with which an agreement under section 1864 is in effect (or, in the case of a State in which no such agency has an agreement under section 1864, by the Secretary) to have attempted in good faith to enter into such an agreement with a hos-

1 pital sufficiently close to the facility to make feasible the
2 transfer between them of patients and the information re-
3 ferred to in paragraph (2), shall be considered to have such
4 an agreement in effect if and for so long as such agency (or
5 the Secretary, as the case may be) finds that to do so is in
6 the public interest and essential to assuring extended care
7 services for persons in the community who are eligible for
8 payments with respect to such services under this title.

9 "Home Health Services

10 "(m) The term 'home health services' means the fol-
11 lowing items and services furnished to an individual, who is
12 under the care of a physician, by a home health agency or by
13 others under arrangements with them made by such agency,
14 under a plan (for furnishing such items and services to such
15 individual) established and periodically reviewed by a
16 physician, which items and services are, except as provided
17 in paragraph (7), provided on a visiting basis in a place of
18 residence used as such individual's home—

19 "(1) part-time or intermittent nursing care pro-
20 vided by or under the supervision of a registered pro-
21 fessional nurse;

22 "(2) physical, occupational, or speech therapy;

23 "(3) medical social services under the direction of
24 a physician;

1 “(4) to the extent permitted in regulations, part-
2 time or intermittent services of a home health aide;

3 “(5) medical supplies (other than drugs and bio-
4 logicals), and the use of medical appliances, while under
5 such a plan;

6 “(6) in the case of a home health agency which
7 is affiliated or under common control with a hospital,
8 medical services provided by an intern or resident-in-
9 training of such hospital, under a teaching program
10 of such hospital approved as provided in the last sen-
11 tence of subsection (b); and

12 “(7) any of the foregoing items and services which
13 are provided on an outpatient basis, under arrangements
14 made by the home health agency, at a hospital or
15 extended care facility, or at a rehabilitation center which
16 meets such standards as may be prescribed in regula-
17 tions, and—

18 “(A) the furnishing of which involves the use
19 of equipment of such a nature that the items and
20 services cannot readily be made available to the in-
21 dividual in such place of residence, or

22 “(B) which are furnished at such facility while
23 he is there to receive any such item or service de-
24 scribed in clause (A),

1 but not including transportation of the individual in
2 connection with any such item or service;
3 excluding, however, any item or service if it would not be
4 included under subsection (b) if furnished to an inpatient
5 of a hospital.

6 "Post-Hospital Home Health Services

7 "(n) The term 'post-hospital home health services'
8 means home health services furnished an individual within
9 one year after his most recent discharge from a hospital of
10 which he was an inpatient for not less than 3 consecutive
11 days or (if later) within one year after his most recent dis-
12 charge from an extended care facility of which he was an
13 inpatient entitled to payment under part A for post-hospital
14 extended care services, but only if the plan covering the
15 home health services (as described in subsection (m)) is
16 established within 14 days after his discharge from such
17 hospital or extended care facility.

18 "Home Health Agency

19 "(o) The term 'home health agency' means a public
20 agency or private organization, or a subdivision of such an
21 agency or organization, which—

22 "(1) is primarily engaged in providing skilled
23 nursing services and other therapeutic services;

24 "(2) has policies, established by a group of pro-

1 fessional personnel (associated with the agency or orga-
2 nization) , including one or more physicians and one or
3 more registered professional nurses, to govern the serv-
4 ices (referred to in paragraph (1)) which it provides,
5 and provides for supervision of such services by a phy-
6 sician or registered professional nurse;

7 “(3) maintains clinical records on all patients;

8 “(4) in the case of an agency or organization in
9 any State in which State or applicable local law provides
10 for the licensing of agencies or organizations of this
11 nature, (A) is licensed pursuant to such law, or (B) is
12 approved, by the agency of such State or locality re-
13 sponsible for licensing agencies or organizations of this
14 nature, as meeting the standards established for such
15 licensing; and

16 “(5) meets such other conditions of participation
17 as the Secretary may find necessary in the interest of
18 the health and safety of individuals who are furnished
19 services by such agency or organization;

20 except that such term shall not include a private organiza-
21 tion which is not a nonprofit organization exempt from
22 Federal income taxation under section 501 of the Internal
23 Revenue Code of 1954 (or a subdivision of such organiza-
24 tion) unless it is licensed pursuant to State law and it meets
25 such additional standards and requirements as may be pre-

1 scribed in regulations; and except that for purposes of part A
2 such term shall not include any agency or organization which
3 is primarily for the care and treatment of mental diseases.

4 “Outpatient Hospital Diagnostic Services

5 “(p) The term ‘outpatient hospital diagnostic services’
6 means diagnostic services—

7 “(1) which are furnished to an individual as an
8 outpatient by a hospital or by others under arrange-
9 ments with them made by a hospital; and

10 “(2) which are ordinarily furnished by such hos-
11 pital (or by others under such arrangements) to its
12 outpatients for the purpose of diagnostic study;
13 excluding, however—

14 “(3) any item or service if it would not be included
15 under subsection (b) if furnished to an inpatient of a
16 hospital; and

17 “(4) any services furnished under such arrange-
18 ments unless furnished in the hospital or in other
19 facilities operated by or under the supervision of the hos-
20 pital or its organized medical staff.

21 “Physicians’ Services

22 “(q) The term ‘physicians’ services’ means professional
23 services performed by physicians, including surgery, consul-
24 tation, and home, office, and institutional calls (but not

1 including services described in the last sentence of subsection
2 (b)).

3 “Physician

4 “(r) The term ‘physician’, when used in connection
5 with the performance of any function or action, means an
6 individual legally authorized to practice medicine and surgery
7 by the State in which he performs such function or action
8 (including a physician within the meaning of section 1101
9 (a) (7)).

10 “Medical and Other Health Services

11 “(s) The term ‘medical and other health services’ means
12 any of the following items or services (unless they would
13 otherwise constitute inpatient hospital services, extended
14 care services, home health services, or physicians’ services) :

15 “(1) diagnostic X-ray and laboratory tests, elec-
16 trocardiograms, basal metabolism readings, electroen-
17 cephalograms, and other diagnostic tests;

18 “(2) X-ray, radium, and radioactive isotope
19 therapy, including materials and services of technicians;

20 “(3) surgical dressings, and splints, casts, and other
21 devices used for reduction of fractures and dislocations;

22 “(4) rental of durable medical equipment, includ-
23 ing iron lungs, oxygen tents, hospital beds, and wheel-
24 chairs used in the patient’s home (including an institu-
25 tion used as his home) ;

1 “(5) ambulance service where the use of other
2 methods of transportation is contraindicated by the indi-
3 vidual’s condition, but only to the extent provided in
4 regulations;

5 “(6) prosthetic devices (other than dental) which
6 replace all or part of an internal body organ, including
7 replacement of such devices; and

8 “(7) leg, arm, back, and neck braces, and artifi-
9 cial legs, arms, and eyes, including replacements if re-
10 quired because of a change in the patient’s physical
11 condition.

12 “Drugs and Biologicals

13 “(t) The term ‘drugs’ and the term ‘biologicals’, except
14 for purposes of subsection (m) (5) of this section, include
15 only such drugs and biologicals, respectively, as are included
16 in the United States Pharmacopoeia or the National Formu-
17 lary, or in New Drugs or Accepted Dental Remedies (ex-
18 cept for any drugs and biologicals unfavorably evaluated
19 therein), or as are approved by the pharmacy and drug
20 therapeutics committee (or equivalent committee) of the
21 medical staff of the hospital furnishing such drugs and
22 biologicals.

23 “Provider of Services

24 “(u) The term ‘provider of services’ means a hospital,
25 extended care facility, or home health agency.

1 "Reasonable Cost

2 “(v) (1) The reasonable cost of any services shall
3 be determined in accordance with regulations establishing
4 the method or methods to be used, and the items to be
5 included, in determining such costs for various types or
6 classes of institutions, agencies, and services; except that in
7 any case to which paragraph (2) or (3) applies, the amount
8 of the payment determined under such paragraph with
9 respect to the services involved shall be considered the
10 reasonable cost of such services. In prescribing the
11 regulations referred to in the preceding sentence, the
12 Secretary shall consider, among other things, the principles
13 generally applied by national organizations or established
14 prepayment organizations (which have developed such prin-
15 ciples) in computing the amount of payment, to be made by
16 persons other than the recipients of services, to providers of
17 services on account of services furnished to such recipients
18 by such providers. Such regulations may provide for de-
19 termination of the costs of services on a per diem, per
20 unit, per capita, or other basis, may provide for using
21 different methods in different circumstances, may provide
22 for the use of estimates of costs of particular items or serv-
23 ices, and may provide for the use of charges or a percentage
24 of charges where this method reasonably reflects the costs.
25 Such regulations shall (A) take into account both direct and

1 indirect costs of providers of services in order that, under the
2 methods of determining costs, the costs with respect to in-
3 dividuals covered by the insurance programs established by
4 this title will not be borne by individuals not so covered, and
5 the costs with respect to individuals not so covered will not
6 be borne by such insurance programs, and (B) provide for
7 the making of suitable retroactive corrective adjustments
8 where, for a provider of services for any fiscal period, the
9 aggregate reimbursement produced by the methods of deter-
10 mining costs proves to be either inadequate or excessive.

11 “(2) (A) If the bed and board furnished as part of
12 inpatient hospital services (including inpatient tuberculosis
13 hospital services), inpatient psychiatric hospital services, or
14 post-hospital extended care services is in accommodations
15 more expensive than semi-private accommodations, the
16 amount taken into account for purposes of payment under
17 this title with respect to such services may not exceed an
18 amount equal to the reasonable cost of such services if fur-
19 nished in such semi-private accommodations unless the more
20 expensive accommodations were required for medical reasons.

21 “(B) Where a provider of services which has an agree-
22 ment in effect under this title furnishes to an individual items
23 or services which are in excess of or more expensive than the
24 items or services with respect to which payment may be
25 made under part A or part B, as the case may be, the Secre-

1 tary shall take into account for purposes of payment to such
2 provider of services only the equivalent of the reasonable cost
3 of the items or services with respect to which such payment
4 may be made.

5 “(3) If the bed and board furnished as part of inpatient
6 hospital services (including inpatient tuberculosis hospital
7 services), inpatient psychiatric hospital services, or post-
8 hospital extended care services is in accommodations other
9 than, but not more expensive than, semi-private accommoda-
10 tions and the use of such other accommodations rather than
11 semi-private accommodations was neither at the request of
12 the patient nor for a reason which the Secretary determines is
13 consistent with the purposes of this title, the amount of the
14 payment with respect to such bed and board under part A
15 or part B, as the case may be, shall be the reasonable cost of
16 such bed and board furnished in semi-private accommodations
17 (determined pursuant to paragraph (1)) minus the differ-
18 ence between the charge customarily made by the hospital or
19 extended care facility for bed and board in semi-private ac-
20 commodatons and the charge customarily made by it for bed
21 and board in the accommodations furnished.

22 “(4) For purposes of this subsection, the term ‘semi-
23 private accommodations’ means two-bed, three-bed, or four-
24 bed accommodations.

1 “Arrangements for Certain Services

2 “(w) The term ‘arrangements’ is limited to arrange-
3 ments under which receipt of payment by the hospital,
4 extended care facility, or home health agency (whether in
5 its own right or as agent), with respect to services for which
6 an individual is entitled to have payment made under this
7 title, discharges the liability of such individual or any other
8 person to pay for the services.

9 “State and United States

10 “(x) The terms ‘State’ and ‘United States’ have the
11 meaning given to them by subsections (h) and (i), respec-
12 tively, of section 210.

13 “EXCLUSIONS FROM COVERAGE

14 “SEC. 1862. (a) Notwithstanding any other provision
15 of this title, no payment may be made under part A or part
16 B for any expenses incurred for items or services—

17 “(1) which are not reasonable and necessary for
18 the diagnosis or treatment of illness or injury or to im-
19 prove the functioning of a malformed body member;

20 “(2) for which the individual furnished such items
21 or services has no legal obligation to pay, and which no
22 other person (by reason of such individual’s membership
23 in a prepayment plan or otherwise) has a legal obliga-
24 tion to provide or pay for;

1 “(3) which are paid for directly or indirectly by a
2 governmental entity (other than under this Act), ex-
3 cept in such cases as the Secretary may specify;

4 “(4) which are not provided within the United
5 States;

6 “(5) which are required as a result of war, or of
7 an act of war, occurring after the effective date of such
8 individual’s current coverage under such part;

9 “(6) which constitute personal comfort items;

10 “(7) where such expenses are for routine physical
11 checkups, eyeglasses or eye examinations for the pur-
12 pose of prescribing, fitting, or changing eyeglasses,
13 hearing aids or examinations therefor, or immunizations;

14 “(8) where such expenses are for orthopedic shoes
15 or other supportive devices for the feet;

16 “(9) where such expenses are for custodial care;

17 “(10) where such expenses are for cosmetic sur-
18 gery or are incurred in connection therewith, except as
19 required for the prompt repair of accidental injury or
20 for improvement of the functioning of a malformed body
21 member; or

22 “(11) where such expenses constitute charges im-
23 posed by immediate relatives of such individual or
24 members of his household.

25 “(b) Payment under this title may not be made with

1 respect to any item or service to the extent that payment has
2 been made, or can reasonably be expected to be made (as
3 determined in accordance with regulations), with respect to
4 such item or service, under a workmen's compensation law or
5 plan of the United States or a State. Any payment under
6 this title with respect to any item or service shall be con-
7 ditioned on reimbursement to the appropriate Trust Fund
8 established by this title when notice or other information is
9 received that payment for such item or service has been made
10 under such a law or plan.

11 "CONSULTATION WITH STATE AGENCIES AND OTHER ORGA-
12 NIZATIONS TO DEVELOP CONDITIONS OF PARTICIPATION
13 FOR PROVIDERS OF SERVICES

14 "SEC. 1863. In carrying out his functions, relating to
15 determination of conditions of participation by providers of
16 services, under subsections (e) (8), (f) (4), (g) (4),
17 (j) (10), and (o) (5) of section 1861, the Secretary shall
18 consult with the Health Insurance Benefits Advisory Council
19 established by section 1867, appropriate State agencies, and
20 recognized national listing or accrediting bodies, and may
21 consult with appropriate local agencies. Such conditions
22 prescribed under any of such subsections may be varied
23 for different areas or different classes of institutions or agen-
24 cies and may, at the request of a State, provide (subject,
25 in the case of hospitals, to the limitation provided in section

1 1861 (e) (8)) higher requirements for such State than for
2 other States.

3 "USE OF STATE AGENCIES TO DETERMINE COMPLIANCE
4 BY PROVIDERS OF SERVICES WITH CONDITIONS OF
5 PARTICIPATION

6 "SEC. 1864. (a) The Secretary shall make an agree-
7 ment with any State which is able and willing to do so under
8 which the services of the State health agency or other appro-
9 priate State agency (or the appropriate local agencies) will
10 be utilized by him for the purpose of determining whether an
11 institution therein is a hospital or extended care facility, or
12 whether an agency therein is a home health agency. To the
13 extent that the Secretary finds it appropriate, an institution
14 or agency which such a State (or local) agency certifies is a
15 hospital, extended care facility, or home health agency (as
16 those terms are defined in section 1861) may be treated as
17 such by the Secretary. The Secretary may also, pursuant to
18 agreement, utilize the services of State health agencies and
19 other appropriate State agencies (and the appropriate local
20 agencies) to do any one or more of the following: (1) to
21 provide consultative services to institutions or agen-
22 cies to assist them (A) to establish and maintain fiscal
23 records necessary for purposes of this title, or otherwise to
24 qualify as hospitals, extended care facilities, or home health
25 agencies, or (B) to provide information which may be nec-

1 essary to permit determination under this title as to whether
2 payments are due and the amounts thereof, and (2) to pro-
3 vide consultative services to institutions, agencies, or organi-
4 zations to assist in the establishment of utilization review
5 procedures meeting the requirements of section 1861 (k) and
6 in evaluating their effectiveness.

7 “(b) The Secretary shall pay any such State, in
8 advance or by way of reimbursement, as may be provided in
9 the agreement with it (and may make adjustments in such
10 payments on account of overpayments or underpayments
11 previously made), for the reasonable cost of performing the
12 functions specified in subsection (a), and for the Federal
13 Hospital Insurance Trust Fund’s fair share of the costs
14 attributable to the planning and other efforts directed toward
15 coordination of activities in carrying out its agreement and
16 other activities related to the provision of services similar to
17 those for which payment may be made under part A, or re-
18 lated to the facilities and personnel required for the provision
19 of such services, or related to improving the quality of such
20 services.

21 “EFFECT OF ACCREDITATION

22 “SEC. 1865. An institution shall be deemed to meet the
23 requirements of the numbered paragraphs of section 1861 (e)
24 (except paragraph (6) thereof) if such institution is accred-
25 ited as a hospital by the Joint Commission on the Accredita-

1 tion of Hospitals. If such Commission, as a condition for
2 accreditation of a hospital, requires a utilization review plan
3 or imposes another requirement which serves substantially
4 the same purpose, the Secretary is authorized to find that all
5 institutions so accredited by the Commission comply also
6 with section 1861 (e) (6). In addition, if the Secretary finds
7 that accreditation of an institution or agency by the American
8 Osteopathic Association or any other national accreditation
9 body provides reasonable assurance that any or all of the con-
10 ditions of section 1861 (e), (j), or (o), as the case may be,
11 are met, he may, to the extent he deems it appropriate, treat
12 such institution or agency as meeting the condition or condi-
13 tions with respect to which he made such finding.

14 "AGREEMENTS WITH PROVIDERS OF SERVICES

15 "SEC. 1866. (a) (1) Any provider of services shall be
16 qualified to participate under this title and shall be eligible
17 for payments under this title if it files with the Secretary an
18 agreement—

19 "(A) not to charge, except as provided in para-
20 graph (2), any individual or any other person for
21 items or services for which such individual is entitled
22 to have payment made under this title (or for which
23 he would be so entitled if such provider of services had
24 complied with the procedural and other requirements
25 under or pursuant to this title or for which such provider

1 is paid pursuant to the provisions of section 1814 (e)
2 or section 1835 (c)), and

3 “(B) to make adequate provision for return (or
4 other disposition, in accordance with regulations) of
5 any moneys incorrectly collected from such individual
6 or other person.

7 “(2) (A) A provider of services may charge such in-
8 dividual or other person (i) the amount of any deduction
9 imposed pursuant to section 1813 (a) (1) or (a) (2) or
10 section 1833 (b) with respect to such items and services
11 (not in excess of the amount customarily charged for such
12 items and services by such provider), and (ii) an amount
13 equal to 20 per centum of the reasonable charges for such
14 items and services (not in excess of 20 per centum of the
15 amount customarily charged for such items and services by
16 such provider) for which payment is made under part B.
17 In the case of items and services described in section 1833
18 (c), clause (ii) of the preceding sentence shall be applied
19 by substituting for 20 percent the proportion which is appro-
20 priate under such section.

21 “(B) Where a provider of services has furnished, at the
22 request of such individual, items or services which are in
23 excess of or more expensive than the items or services with
24 respect to which payment may be made under this title,
25 such provider of services may also charge such individual or

1 other person for such more expensive items or services to the
2 extent that the amount customarily charged by it for the
3 items or services furnished at such request exceeds the
4 amount customarily charged by it for the items or services
5 with respect to which payment may be made under this
6 title.

7 “(C) A provider of services may also charge any such
8 individual for any whole blood furnished him with respect
9 to which a deductible is imposed under section 1813 (a) (3)
10 or 1833 (d), except that (i) any excess of such charge over
11 the cost to such provider for the blood shall be deducted
12 from any payment to such provider under this title, (ii) no
13 such charge may be imposed for the cost of administration
14 of such blood, and (iii) such charge may not be made to
15 the extent such blood has been replaced on behalf of such
16 individual or arrangements have been made for its replace-
17 ment on his behalf.

18 “(b) An agreement with the Secretary under this sec-
19 tion may be terminated—

20 “(1) by the provider of services at such time and
21 upon such notice to the Secretary and the public as may
22 be provided in regulations, except that notice of more
23 than 6 months shall not be required, or

24 “(2) by the Secretary at such time and upon such
25 reasonable notice to the provider of services and the

1 public as may be specified in regulations, but only
2 after the Secretary has determined (A) that such pro-
3 vider of services is not complying substantially with
4 the provisions of such agreement, or with the provisions
5 of this title and regulations thereunder, or (B) that
6 such provider of services no longer substantially meets
7 the applicable provisions of section 1861, or (C) that
8 such provider of services has failed to provide such
9 information as the Secretary finds necessary to determine
10 whether payments are or were due under this title
11 and the amounts thereof, or has refused to permit such
12 examination of its fiscal and other records by or on behalf
13 of the Secretary as may be necessary to verify such
14 information.

15 Any termination shall be applicable—

16 “(3) in the case of inpatient hospital services (in-
17 cluding inpatient tuberculosis hospital services), in-
18 patient psychiatric hospital services, or post-hospital
19 extended care services, with respect to such services
20 furnished to any individual who is admitted to the hos-
21 pital or extended care facility furnishing such services
22 on or after the effective date of such termination,

23 “(4) (A) with respect to home health services
24 furnished to an individual under a plan therefor estab-
25 lished on or after the effective date of such termination,

1 or (B) if a plan is established before such effective
2 date, with respect to such services furnished to such
3 individual after the calendar year in which such termina-
4 tion is effective, and

5 “(5) with respect to any other items and services
6 furnished on or after the effective date of such
7 termination.

8 “(c) Where an agreement filed under this title by a
9 provider of services has been terminated by the Secretary,
10 such provider may not file another agreement under this
11 title unless the Secretary finds that the reason for the termi-
12 nation has been removed and that there is reasonable assur-
13 ance that it will not recur.

14 “(d) If the Secretary finds that there is a substantial
15 failure to make timely review in accordance with section
16 1861 (k) of long-stay cases in a hospital or extended care
17 facility, he may, in lieu of terminating his agreement with
18 such hospital or facility, decide that, with respect to any
19 individual admitted to such hospital or facility after a subse-
20 quent date specified by him, no payment shall be made under
21 this title for inpatient hospital services (including inpatient
22 tuberculosis hospital services), or inpatient psychiatric hos-
23 pital services, after the 20th day of a continuous period of
24 such services or for post-hospital extended care services after
25 such day of a continuous period of such care as is prescribed

1 in or pursuant to regulations, as the case may be. Such deci-
2 sion may be made effective only after such notice to the hos-
3 pital, or (in the case of an extended care facility) to the
4 facility and the hospital or hospitals with which it has a trans-
5 fer agreement, and to the public, as may be prescribed by
6 regulations, and its effectiveness shall terminate when the
7 Secretary finds that the reason therefor has been removed and
8 that there is reasonable assurance that it will not recur. The
9 Secretary shall not make any such decision except after rea-
10 sonable notice and opportunity for hearing to the institution
11 or agency affected thereby.

12 "HEALTH INSURANCE BENEFITS ADVISORY COUNCIL

13 "SEC. 1867. For the purpose of advising the Secretary
14 on matters of general policy in the administration of this title
15 and in the formulation of regulations under this title, there is
16 hereby created a Health Insurance Benefits Advisory Coun-
17 cil which shall consist of 16 persons, not otherwise in
18 the employ of the United States, appointed by the Secretary
19 without regard to the civil service laws. The Secretary shall
20 from time to time appoint one of the members to serve as
21 Chairman. The members shall include persons who are out-
22 standing in fields related to hospital, medical, and other
23 health activities, and at least one person who is representa-
24 tive of the general public. Each member shall hold office for

1 a term of 4 years, except that any member appointed to
2 fill a vacancy occurring prior to the expiration of the term
3 for which his predecessor was appointed shall be appointed
4 for the remainder of such term, and except that the terms of
5 office of the members first taking office shall expire, as designated by the Secretary at the time of appointment, four at the
6 end of the first year, four at the end of the second year, four
7 at the end of the third year, and four at the end of the fourth
8 year after the date of appointment. A member shall not be
9 eligible to serve continuously for more than 2 terms. The
10 Secretary may, at the request of the Council or otherwise,
11 appoint such special advisory professional or technical committees as may be useful in carrying out this title. Members
12 of the Advisory Council and members of any such advisory or
13 technical committee, while attending meetings or conferences thereof or otherwise serving on business of the Advisory Council or of such committee, shall be entitled
14 to receive compensation at rates fixed by the Secretary, but
15 not exceeding \$100 per day, including travel time, and while
16 so serving away from their homes or regular places of business they may be allowed travel expenses, including per
17 diem in lieu of subsistence, as authorized by section 5 of the
18 Administrative Expenses Act of 1946 (5 U.S.C. 73b-2)
19 for persons in the Government service employed intermittently. The Advisory Council shall meet as frequently as

1 the Secretary deems necessary. Upon request of 4 or more
2 members, it shall be the duty of the Secretary to call a meet-
3 ing of the Advisory Council.

4 "NATIONAL MEDICAL REVIEW COMMITTEE

5 "SEC. 1868. (a) There is hereby created a National
6 Medical Review Committee (hereinafter in this section re-
7 ferred to as the 'Committee') which shall consist of nine
8 persons, not otherwise in the employ of the United States,
9 appointed by the Secretary without regard to the civil service
10 laws. The Secretary shall from time to time appoint one of
11 the members to serve as chairman. The members shall be
12 selected from among individuals who are representative of
13 organizations and associations of professional personnel in the
14 field of medicine and other individuals who are outstanding
15 in the field of medicine or in related fields; except that at
16 least one member shall be representative of the general pub-
17 lic, and at least a majority of the members shall be physi-
18 cians. Each member shall hold office for a term of three
19 years, except that any member appointed to fill a vacancy
20 occurring prior to the expiration of the term for which his
21 predecessor was appointed shall be appointed for the re-
22 mainder of such term, and except that the terms of office of
23 the members first taking office shall expire, as designated by
24 the Secretary at the time of appointment, three at the end of
25 the first year, three at the end of the second year, and three at

1 the end of the third year after the date of appointment. A
2 member shall not be eligible to serve continuously for more
3 than two terms.

4 “(b) Members of the Committee, while attending
5 meetings or conferences thereof or otherwise serving on
6 business of the Committee, shall be entitled to receive com-
7 pensation at rates fixed by the Secretary, but not exceeding
8 \$100 per day, including travel time, and while so serving
9 away from their homes or regular places of business they
10 may be allowed travel expenses, including per diem in lieu
11 of subsistence, as authorized by section 5 of the Admin-
12 istrative Expenses Act of 1946 (5 U.S.C. 73b-2) for
13 persons in the Government service employed intermittently.

14 “(c) It shall be the function of the Committee to study
15 the utilization of hospital and other medical care and services
16 for which payment may be made under this title with a
17 view to recommending any changes which may seem de-
18 sirable in the way in which such care and services are
19 utilized or in the administration of the programs established
20 by this title, or in the provisions of this title. The Com-
21 mittee shall make an annual report to the Secretary of the
22 results of its study, including any recommendations it may
23 have with respect thereto, and such report shall be trans-
24 mitted promptly by the Secretary to the Congress.

25 “(d) The Committee is authorized to engage such tech-

1 nical assistance as may be required to carry out its functions,
2 and the Secretary shall, in addition, make available to the
3 Committee such secretarial, clerical, and other assistance
4 and such pertinent data obtained and prepared by the De-
5 partment of Health, Education, and Welfare as the Com-
6 mittee may require to carry out its functions.

7 "DETERMINATIONS; APPEALS

8 "SEC. 1869. (a) The determination of whether an
9 individual is entitled to benefits under part A or part B,
10 and the determination of the amount of benefits under part A,
11 shall be made by the Secretary in accordance with regulations
12 prescribed by him.

13 "(b) Any individual dissatisfied with any determina-
14 tion under subsection (a) as to entitlement under part A or
15 part B, or as to amount of benefits under part A where the
16 matter in controversy is \$1,000 or more, shall be entitled
17 to a hearing thereon by the Secretary to the same extent as
18 is provided in section 205 (b), and to judicial review of the
19 Secretary's final decision after such hearing as is provided
20 in section 205 (g).

21 "(c) Any institution or agency dissatisfied with any
22 determination by the Secretary that it is not a provider of
23 services, or with any determination described in section 1866
24 (b) (2), shall be entitled to a hearing thereon by the Secre-
25 tary (after reasonable notice and opportunity for hearing)

1 to the same extent as is provided in section 205 (b), and
2 to judicial review of the Secretary's final decision after such
3 hearing as is provided in section 205 (g).

4 "OVERPAYMENTS ON BEHALF OF INDIVIDUALS

5 "SEC. 1870. (a) Any payment under this title to any
6 provider of services with respect to any items or services
7 furnished any individual shall be regarded as a payment to
8 such individual.

9 "(b) Where—

10 "(1) more than the correct amount is paid under
11 this title to a provider of services or other person for
12 items or services furnished an individual and the Secre-
13 tary determines that, within such period as he may
14 specify, the excess over the correct amount cannot be
15 recouped from such provider of services or other person,
16 or

17 "(2) any payment has been made under section
18 1814 (e) or 1835 (c) to a provider of services or other
19 person for items or services furnished an individual,
20 proper adjustments shall be made, under regulations pre-
21 scribed (after consultation with the Railroad Retirement
22 Board) by the Secretary, by decreasing subsequent pay-
23 ments—

24 "(3) to which such individual is entitled under

1 title II of this Act or under the Railroad Retirement
2 Act of 1937, as the case may be, or

3 “(4) if such individual dies before such adjustment
4 has been completed, to which any other individual is
5 entitled under title II of this Act or under the Railroad
6 Retirement Act of 1937, as the case may be, with re-
7 spect to the wages and self-employment income or the
8 compensation constituting the basis of the benefits of
9 such deceased individual under title II of such Act.

10 As soon as practicable after any adjustment under paragraph
11 (3) or (4) is determined to be necessary, the Secretary,
12 for purposes of this section, section 1817(g), and section
13 1834(f), shall certify (to the Railroad Retirement Board
14 if the adjustment is to be made by decreasing subsequent
15 payments under the Railroad Retirement Act of 1937) the
16 amount of the overpayment as to which the adjustment is
17 to be made.

18 “(c) There shall be no adjustment as provided in sub-
19 section (b) (nor shall there be recovery) in any case where
20 the incorrect payment has been made (including payments
21 under sections 1814(e) and 1835(c)) with respect to an
22 individual who is without fault and where such adjustment
23 (or recovery) would defeat the purposes of title II or would
24 be against equity and good conscience.

1 “(d) No certifying or disbursing officer shall be held
2 liable for any amount certified or paid by him to any pro-
3 vider of services or other person where the adjustment or
4 recovery of such amount is waived under subsection (c) or
5 where adjustment under subsection (b) is not completed
6 prior to the death of all persons against whose benefits such
7 adjustment is authorized.

8 “REGULATIONS

9 “SEC. 1871. The Secretary shall prescribe such regula-
10 tions as may be necessary to carry out the administration of
11 the insurance programs under this title. When used in this
12 title, the term ‘regulations’ means, unless the context other-
13 wise requires, regulations prescribed by the Secretary.

14 “APPLICATION OF CERTAIN PROVISIONS OF TITLE II

15 “SEC. 1872. The provisions of sections 206, 208, and
16 216 (j), and of subsections (a), (d), (e), (f), (h), (i),
17 (j), (k), and (l) of section 205, shall also apply with re-
18 spect to this title to the same extent as they are applicable
19 with respect to title II.

20 “DESIGNATION OF ORGANIZATION OR PUBLICATION

21 BY NAME

22 “SEC. 1873. Designation in this title, by name, of any
23 nongovernmental organization or publication shall not be
24 affected by change of name of such organization or pub-
25 lication, and shall apply to any successor organization or

1 publication which the Secretary finds serves the purpose
2 for which such designation is made.

3 "ADMINISTRATION

4 "SEC. 1874. (a) Except as otherwise provided in this
5 title, the insurance programs established by this title shall be
6 administered by the Secretary. The Secretary may perform
7 any of his functions under this title directly, or by contract
8 providing for payment in advance or by way of reimburse-
9 ment, and in such installments, as the Secretary may deem
10 necessary.

11 "(b) The Secretary may contract with any person,
12 agency, or institution to secure on a reimbursable basis such
13 special data, actuarial information, and other information as
14 may be necessary in the carrying out of his functions under
15 this title.

16 "STUDIES AND RECOMMENDATIONS

17 "SEC. 1875. (a) The Secretary shall carry on studies
18 and develop recommendations to be submitted from time to
19 time to the Congress relating to health care of the aged, in-
20 cluding studies and recommendations concerning (1) the
21 adequacy of existing personnel and facilities for health care
22 for purposes of the programs under parts A and B; (2)
23 methods for encouraging the further development of efficient
24 and economical forms of health care which are a constructive
25 alternative to inpatient hospital care; (3) the effects of the

1 deductibles and coinsurance provisions upon beneficiaries,
2 persons who provide health services, and the financing of
3 the program; and (4) the desirability of broadening or
4 otherwise modifying the provisions of this title which au-
5 thorize payment for additional days of post-hospital extended
6 care services in cases where the number of days of inpatient
7 hospital services in a spell of illness for which payment is
8 made is less than the maximum number of days for which
9 such payment could be made.

10 “(b) The Secretary shall make a continuing study of
11 the operation and administration of the insurance programs
12 under parts A and B, and shall transmit to the Congress an-
13 nually a report concerning the operation of such programs.”

14 (b) If—

15 (1) an individual was eligible to enroll under sec-
16 tion 1837 (c) of the Social Security Act before April 1,
17 1966, but failed to enroll before such date, and

18 (2) it is shown to the satisfaction of the Secretary
19 of Health, Education, and Welfare that there was good
20 cause for such failure to enroll before April 1, 1966,
21 such individual may enroll pursuant to this subsection at any
22 time before October 1, 1966. The determination of what
23 constitutes good cause for purposes of the preceding sentence
24 shall be made in accordance with regulations of the Secre-
25 tary. In the case of any individual who enrolls pursuant to

1 this subsection, the coverage period (within the meaning of
2 section 1838 of the Social Security Act) shall begin on the
3 first day of the 6th month after the month in which he so
4 enrolls.

5 TRANSITIONAL PROVISION ON ELIGIBILITY OF PRESENTLY
6 UNINSURED INDIVIDUALS FOR HOSPITAL INSURANCE
7 BENEFITS

8 SEC. 103. (a) Anyone who—

9 (1) has attained the age of 65,

10 (2) (A) attained such age before 1968, or (B) has
11 not less than 3 quarters of coverage (as defined in title II
12 of the Social Security Act or section 5 (1) of the Railroad
13 Retirement Act of 1937), whenever acquired, for each
14 calendar year elapsing after 1965 and before the year
15 in which he attained such age,

16 (3) is not, and upon filing application for monthly
17 insurance benefits under section 202 of the Social
18 Security Act would not be, entitled to hospital insurance
19 benefits under section 226 of such Act, and is not
20 certifiable as a qualified railroad retirement beneficiary
21 under section 21 of the Railroad Retirement Act of
22 1937 (as added by section 105 (a) of this Act),

23 (4) is a resident of the United States (as defined
24 in section 210 (i) of the Social Security Act), and is
25 a citizen of the United States or an individual who has

1 resided in the United States (as so defined) continu-
2 ously during the 10 years immediately preceding the
3 month in which he files application under this section,
4 and

5 (5) has filed an application under this section in
6 such manner and in accordance with such other require-
7 ments as may be prescribed in regulations of the Secre-
8 tary,

9 shall (subject to the limitations in this section) be deemed,
10 solely for purposes of section 226 of the Social Security Act,
11 to be entitled to monthly insurance benefits under such
12 section 202 for each month, beginning with the first month
13 in which he meets the requirements of this subsection and
14 ending with the month in which he dies, or, if earlier,
15 the month before the month in which he becomes (or
16 upon filing application for monthly insurance benefits
17 under section 202 of such Act would become) entitled to
18 hospital insurance benefits under section 226 or becomes
19 certifiable as a qualified railroad retirement beneficiary. An
20 individual who would have met the preceding requirements of
21 this subsection in any month had he filed application under
22 paragraph (5) hereof before the end of such month shall
23 be deemed to have met such requirements in such month
24 if he files such application before the end of the twelfth month
25 following such month. No application under this section

1 which is filed by an individual before the first month in
2 which he meets the requirements of paragraphs (1), (2),
3 (3), and (4) shall be accepted as an application for pur-
4 poses of this section.

5 (b) The provisions of subsection (a) shall not apply
6 to any individual who—

7 (1) is, at the beginning of the first month in which
8 he meets the requirements of subsection (a), a member
9 of any organization referred to in section 210 (a) (17)
10 of the Social Security Act,

11 (2) has, prior to the beginning of such first month,
12 been convicted of any offense listed in section 202 (u)
13 of the Social Security Act, or

14 (3) at the beginning of such first month, is
15 covered by an enrollment in a health benefits plan under
16 the Federal Employees Health Benefits Act of 1959 or
17 could have been so covered had he or some other in-
18 dividual availed himself of opportunities to enroll in a
19 health benefits plan under such Act and (where the
20 Federal employee has retired) to continue such enroll-
21 ment after retirement.

22 (c) There are authorized to be appropriated to the
23 Federal Hospital Insurance Trust Fund (established by
24 section 1817 of the Social Security Act) from time to time
25 such sums as the Secretary deems necessary, on account of—

1 (1) payments made from such Trust Fund under
2 part A of title XVIII of such Act with respect to indi-
3 viduals who are entitled to hospital insurance benefits
4 under section 226 of such Act solely by reason of this
5 section,

6 (2) the additional administrative expenses result-
7 ing therefrom, and

8 (3) any loss in interest to such Trust Fund result-
9 ing from the payment of such amounts,
10 in order to place such Trust Fund in the same position in
11 which it would have been if the preceding subsections of this
12 section had not been enacted.

13 SUSPENSION IN CASE OF ALIENS; PERSONS CONVICTED OF
14 SUBVERSIVE ACTIVITIES

15 SEC. 104. (a) (1) Section 202 (t) of the Social Secu-
16 rity Act is amended by adding at the end thereof the follow-
17 ing new paragraph:

18 “(9) No payments shall be made under part A of title
19 XVIII with respect to items or services furnished to an indi-
20 vidual in any month for which the prohibition in paragraph
21 (1) against payment of benefits to him is applicable (or
22 would be if he were entitled to any such benefits).”

23 (2) Section 202 (u) of such Act is amended by striking
24 out “and” before the phrase “in determining the amount of

1 any such benefit payable to such individual for any such
2 month,” and inserting after such phrase “and in determining
3 whether such individual is entitled to insurance benefits under
4 part A of title XVIII for any such month,”.

5 (b) (1) No payments shall be made under part B of
6 title XVIII of the Social Security Act with respect to ex-
7 penses incurred by an individual during any month for which
8 such individual may not be paid monthly benefits under title
9 II of such Act (or for which such monthly benefits would be
10 suspended if he were otherwise entitled thereto) by reason
11 of section 202 (t) of such Act (relating to suspension of ben-
12 efits of aliens who are outside the United States).

13 (2) An individual who has been convicted of any
14 offense under (1) chapter 37 (relating to espionage and
15 censorship), chapter 105 (relating to sabotage), or chapter
16 115 (relating to treason, sedition, and subversive activities)
17 of title 18 of the United States Code, or (2) section 4, 112,
18 or 113 of the Internal Security Act of 1950, as amended,
19 may not enroll under part B of title XVIII of the Social
20 Security Act.

21 RAILROAD RETIREMENT AMENDMENTS

22 SEC. 105. (a) (1) The Railroad Retirement Act of 1937
23 is amended by adding after section 20 the following new
24 section:

1 “HOSPITAL INSURANCE BENEFITS FOR THE AGED

2 “SEC. 21. For the purposes of part A of title XVIII
3 of the Social Security Act, in order to provide hospital
4 insurance benefits for annuitants, pensioners, and certain
5 other aged individuals, the Board shall, upon request of the
6 Secretary of Health, Education, and Welfare, certify to the
7 Secretary the name of any individual who has attained age
8 65 and who (1) is entitled to an annuity or pension under
9 this Act, (2) would be entitled to such an annuity had he
10 (i) ceased compensated service and (in the case of a spouse)
11 had such spouse's husband or wife ceased compensated serv-
12 ice and (ii) applied for such annuity, or (3) bears a rela-
13 tionship to an employee which, by reason of section 3 (e) of
14 such Act, has been, or would be, taken into account in calcu-
15 lating the amount of an annuity of such employee or his
16 survivors. Such a certification shall include such additional
17 information as may be necessary to carry out the provisions
18 of part A of title XVIII of the Social Security Act, and shall
19 become effective on the date of certification or on such earlier
20 date not more than one year prior to the date of certification
21 as the Board states that such individual first met the require-
22 ments for certification. The Board shall notify the Secretary
23 of the date on which such individual no longer meets the
24 requirements of this section.”

25 (2) For purposes of section 21 of the Railroad Retire-

1 ment Act of 1937 (and sections 1840, 1843, and 1870 of
2 the Social Security Act), entitlement to an annuity or pen-
3 sion under the Railroad Retirement Act of 1937 shall be
4 deemed to include entitlement under the Railroad Retirement
5 Act of 1935.

6 (b) (1) Section 3201 of the Internal Revenue Code of
7 1954 (relating to rate of tax on employees under the Rail-
8 road Retirement Tax Act) is amended by striking out “the
9 rate of the tax imposed with respect to wages by section
10 3101 at such time exceeds the rate provided by paragraph
11 (2) of such section 3101 as amended by the Social Security
12 Amendments of 1956” and inserting in lieu thereof “the rate
13 of the tax imposed with respect to wages by section 3101 (a)
14 at such time exceeds $2\frac{3}{4}$ percent (the rate provided by para-
15 graph (2) of section 3101 as amended by the Social Secu-
16 rity Amendments of 1956) ”.

17 (2) Section 3211 of such Code (relating to the rate of
18 tax on employee representatives under the Railroad Retire-
19 ment Tax Act) is amended by striking out “the rate of the
20 tax imposed with respect to wages by section 3101 at such
21 time exceeds the rate provided by paragraph (2) of such
22 section 3101 as amended by the Social Security Amendments
23 of 1956” and inserting in lieu thereof “the rate of the tax
24 imposed with respect to wages by section 3101 (a) at such

1 time exceeds $2\frac{3}{4}$ percent (the rate provided by paragraph
2 (2) of section 3101 as amended by the Social Security
3 Amendments of 1956) ”.

4 (3) Section 3221 (b) of such Code (relating to the rate
5 of tax on employers under the Railroad Retirement Tax Act)
6 is amended by striking out “the rate of the tax imposed with
7 respect to wages by section 3111 at such time exceeds the
8 rate provided by paragraph (2) of such section 3111 as
9 amended by the Social Security Amendments of 1956” and
10 inserting in lieu thereof “the rate of the tax imposed with
11 respect to wages by section 3111 (a) at such time exceeds
12 $2\frac{3}{4}$ percent (the rate provided by paragraph (2) of section
13 3111 as amended by the Social Security Amendments of
14 1956) ”.

15 (4) The amendments made by this subsection shall be
16 effective with respect to compensation paid for services
17 rendered after December 31, 1965.

18 (c) For amendments preserving relationship between
19 the railroad retirement and old-age, survivors, and disability
20 insurance systems, see section 326 of this Act.

21 MEDICAL EXPENSE DEDUCTION

22 SEC. 106. (a) Subsection (a) of section 213 of the
23 Internal Revenue Code of 1954 (relating to allowance of
24 deduction) is amended to read as follows:

25 “(a) ALLOWANCE OF DEDUCTION.—There shall be

1 allowed as a deduction the following amounts, not compen-
2 sated for by insurance or otherwise—

3 “(1) the amount by which the amount of the
4 expenses paid during the taxable year (reduced by any
5 amount deductible under paragraph (2)) for medical
6 care of the taxpayer, his spouse, and dependents (as
7 defined in section 152) exceeds 3 percent of the
8 adjusted gross income, and

9 “(2) an amount (not in excess of \$250) equal to
10 one-half of the expenses paid during the taxable year for
11 insurance which constitutes medical care for the tax-
12 payer, his spouse, and dependents.”

13 (b) The second sentence of section 213 (b) of such
14 Code (relating to limitation with respect to medicine and
15 drugs) is repealed.

16 (c) Section 213 (e) of such Code (relating to defini-
17 tions) is amended by renumbering paragraph (2) as
18 paragraph (4), and by striking out paragraph (1) and
19 inserting in lieu thereof the following:

20 “(1) The term ‘medical care’ means amounts paid—

21 “(A) for the diagnosis, cure, mitigation, treat-
22 ment, or prevention of disease, or for the purpose of
23 affecting any structure or function of the body,

24 “(B) for transportation primarily for and es-

1 sential to medical care referred to in subparagraph
2 (A), or

3 “(C) for insurance (including amounts paid as
4 premiums under part B of title XVIII of the Social
5 Security Act, relating to supplementary health in-
6 surance for the aged) covering medical care re-
7 ferred to in subparagraphs (A) and (B).

8 “(2) In the case of an insurance contract under
9 which amounts are payable for other than medical care
10 referred to in subparagraphs (A) and (B) of para-
11 graph (1) —

12 “(A) no amount shall be treated as paid for
13 insurance to which paragraph (1) (C) applies un-
14 less the charge for such insurance is separately
15 stated in the contract,

16 “(B) the amount taken into account as the
17 amount paid for such insurance shall not exceed
18 such charge, and

19 “(C) no amount shall be treated as paid for
20 such insurance if the amount specified in the con-
21 tract as the charge for such insurance is unreason-
22 ably large in relation to the total charges under the
23 contract.

24 “(3) Subject to the limitations of paragraph (2),
25 premiums paid during the taxable year by a taxpayer

1 before he attains the age of 65 for insurance covering
2 medical care (within the meaning of subparagraphs
3 (A) and (B) of paragraph (1)) for the taxpayer,
4 his spouse, or a dependent after the taxpayer attains
5 the age of 65 shall be treated as expenses paid during
6 the taxable year for insurance which constitutes medical
7 care if premiums for such insurance are payable (on
8 a level payment basis) under the contract for a period
9 of 10 years or more or until the year in which the
10 taxpayer attains the age of 65 (but in no case for a
11 period of less than 5 years).”

12 (d) Section 213 (g) of such Code (relating to maxi-
13 mum limitation if taxpayer or spouse has attained age 65 and
14 is disabled) is amended—

15 (1) by striking out “Has Attained Age 65 and” in
16 the heading;

17 (2) by striking out “has attained the age of 65
18 before the close of the taxable year and” each place
19 it appears in the text; and

20 (3) by striking out “have attained the age of 65
21 before the close of the taxable year and” in paragraph
22 (1) (B).

23 (e) The amendments made by this section shall apply
24 to taxable years beginning after December 31, 1966.

1 RECEIPTS FOR EMPLOYEES MUST SHOW TAXES SEPARATELY

2 SEC. 107. Section 6051 (c) of the Internal Revenue
3 Code of 1954 (relating to additional requirements) is
4 amended by adding at the end thereof the following new
5 sentence: "The statements required under this section shall
6 also show the proportion of the total amount withheld as tax
7 under section 3101 which is for financing the cost of hospital
8 insurance benefits under part A of title XVIII of the Social
9 Security Act."

10 TECHNICAL AND ADMINISTRATIVE AMENDMENTS RELATING
11 TO TRUST FUNDS

12 SEC. 108. (a) (1) Section 201 (a) (3) of the Social
13 Security Act is amended by inserting "(other than sections
14 3101 (b) and 3111 (b))" after "chapter 21" each place it
15 appears therein.

16 (2) Section 201 (a) (4) of such Act is amended by
17 inserting "(other than section 1401 (b))" after "chapter 2"
18 and after "such subchapter or chapter".

19 (3) Section 201 (g) (1) of such Act is amended to
20 read as follows:

21 "(1) (A) There are authorized to be made available
22 for expenditure, out of any or all of the Trust Funds (which
23 for purposes of this paragraph shall include also the Federal
24 Hospital Insurance Trust Fund and the Federal Supple-
25 mentary Health Insurance Benefits Trust Fund established

1 by title XVIII), such amounts as the Congress may deem
2 appropriate to pay the costs of the part of the adminis-
3 tration of this title and title XVIII for which the Secretary of
4 Health, Education, and Welfare is responsible. During each
5 fiscal year or after the close of such fiscal year (or at both
6 times), the Secretary of Health, Education, and Welfare
7 shall analyze the costs of administration of this title and
8 title XVIII during the appropriate part or all of such fiscal
9 year in order to determine the portion of such costs which
10 should be borne by each of the Trust Funds and shall certify
11 to the Managing Trustee the amount, if any, which should be
12 transferred among such Trust Funds in order to assure that
13 each of the Trust Funds bears its proper share of the costs
14 incurred during such fiscal year for the part of the adminis-
15 tration of this title and title XVIII for which the Secretary
16 of Health, Education, and Welfare is responsible. The
17 Managing Trustee is authorized and directed to transfer any
18 such amount (determined under the preceding sentence)
19 among such Trust Funds in accordance with any certification
20 so made.

21 “(B) The Managing Trustee is directed to pay from the
22 Trust Funds into the Treasury the amounts estimated by him
23 which will be expended, out of moneys appropriated from
24 the general funds in the Treasury, during each calendar
25 quarter by the Treasury Department for the part of the

1 administration of this title and title XVIII for which the
2 Treasury Department is responsible and for the administra-
3 tion of chapters 2 and 21 of the Internal Revenue Code of
4 1954. Such payments shall be covered into the Treasury
5 as repayment to the account for reimbursement of expenses
6 incurred in connection with such administration of this title
7 and title XVIII and chapters 2 and 21 of the Internal
8 Revenue Code of 1954.”

9 (4) Section 201 (g) (2) of such Act is amended by
10 inserting after “the amount estimated by him as taxes” the
11 following: “imposed under section 3101 (a)”.

12 (5) Section 201 (h) of such Act is amended by insert-
13 ing “(other than section 226)” after “this title”.

14 (b) Section 218 (h) (1) of such Act is amended by
15 striking out “Trust Funds in the ratio in which amounts are
16 appropriated to such Funds pursuant to subsections (a) (3)
17 and (b) (1) of section 201” and inserting in lieu thereof
18 “Trust Funds and the Federal Hospital Insurance Trust
19 Fund in the ratio in which amounts are appropriated to such
20 Funds pursuant to subsection (a) (3) of section 201, subsec-
21 tion (b) (1) of such section, and subsection (a) (1) of
22 section 1817, respectively”.

23 (c) Section 1106 (b) of such Act is amended by striking
24 out “and the Federal Disability Insurance Trust Fund” and
25 inserting in lieu thereof “, the Federal Disability Insurance

1 Trust Fund, the Federal Hospital Insurance Trust Fund,
2 and the Federal Supplementary Health Insurance Benefits
3 Trust Fund”.

4 ADVISORY COUNCIL ON SOCIAL SECURITY

5 SEC. 109. (a) Title VII of the Social Security Act is
6 amended by adding at the end thereof the following new
7 section:

8 “ADVISORY COUNCIL ON SOCIAL SECURITY

9 “SEC. 706. (a) During 1968 and every fifth year there-
10 after, the Secretary shall appoint an Advisory Council on
11 Social Security for the purpose of reviewing the status of
12 the Federal Old-Age and Survivors Insurance Trust Fund,
13 the Federal Disability Insurance Trust Fund, the Federal
14 Hospital Insurance Trust Fund, and the Federal Supple-
15 mentary Health Insurance Benefits Trust Fund in relation to
16 the long-term commitments of the old-age, survivors, and dis-
17 ability insurance program and the programs under parts A
18 and B of title XVIII, and of reviewing the scope of coverage
19 and the adequacy of benefits under, and all other aspects of,
20 these programs, including their impact on the public assist-
21 ance programs under this Act.

22 “(b) Each such Council shall consist of the Commis-
23 sioner of Social Security, as Chairman, and 12 other persons,
24 appointed by the Secretary without regard to the civil serv-
25 ice laws. The appointed members shall, to the extent pos-

1 sible, represent organizations of employers and employees in
2 equal numbers, and represent self-employed persons and the
3 public.

4 “(c) (1) Any Council appointed hereunder is author-
5 ized to engage such technical assistance, including actuarial
6 services, as may be required to carry out its functions, and
7 the Secretary shall, in addition, make available to such
8 Council such secretarial, clerical, and other assistance and
9 such actuarial and other pertinent data prepared by the
10 Department of Health, Education, and Welfare as it may
11 require to carry out such functions.

12 “(2) Appointed members of any such Council, while
13 serving on business of the Council (inclusive of travel time),
14 shall receive compensation at rates fixed by the Secretary, but
15 not exceeding \$100 per day and, while so serving away from
16 their homes or regular places of business, they may be
17 allowed travel expenses, including per diem in lieu of sub-
18 sistence, as authorized by section 5 of the Administrative
19 Expenses Act of 1946 (5 U.S.C. 73b-2) for persons in the
20 Government employed intermittently.

21 “(d) Each such Council shall submit reports of its find-
22 ings and recommendations to the Secretary not later than
23 January 1 of the second year after the year in which it is
24 appointed, and such reports and recommendations shall
25 thereupon be transmitted to the Congress and to the Board of

1 Trustees of each of the Trust Funds. The reports required
2 by this subsection shall include—

3 “(1) a separate report with respect to the old-age,
4 survivors, and disability insurance program under title
5 II and of the taxes imposed under sections 1401 (a) ,
6 3101 (a) , and 3111 (a) of the Internal Revenue Code
7 of 1954,

8 “(2) a separate report with respect to the hospital
9 insurance program under part A of title XVIII and of
10 the taxes imposed by sections 1401 (b) , 3101 (b) , and
11 3111 (b) of the Internal Revenue Code of 1954, and

12 “(3) a separate report with respect to the supple-
13 mentary health insurance benefits program established
14 by part B of title XVIII and of the financing thereof.

15 After the date of the transmittal to the Congress of the re-
16 ports required by this subsection, the Council shall cease to
17 exist.”

18 (b) Effective January 1, 1966, section 116 (e) of the
19 Social Security Amendments of 1956 is repealed.

20 MEANING OF TERM “SECRETARY”

21 SEC. 110. As used in this Act, and in the provisions of
22 the Social Security Act amended by this Act, the term “Sec-
23 retary”, unless the context otherwise requires, means the
24 Secretary of Health, Education, and Welfare.

1 PART 2—GRANTS TO STATES FOR MEDICAL ASSISTANCE
2 PROGRAMS

3 ESTABLISHMENT OF PROGRAMS

4 SEC. 121. (a) The Social Security Act is amended by
5 adding at the end thereof (after the new title XVIII added
6 by section 102) the following new title:

7 “TITLE XIX—GRANTS TO STATES FOR MEDICAL
8 ASSISTANCE PROGRAMS

9 “APPROPRIATION

10 “SEC. 1901. For the purpose of enabling each State, as
11 far as practicable under the conditions in such State, to fur-
12 nish (1) medical assistance on behalf of families with de-
13 pendent children and of aged, blind, or permanently and
14 totally disabled individuals, whose income and resources are
15 insufficient to meet the costs of necessary medical services,
16 and (2) rehabilitation and other services to help such fam-
17 ilies and individuals attain or retain capability for independ-
18 ence or self-care, there is hereby authorized to be appropri-
19 ated for each fiscal year a sum sufficient to carry out the
20 purposes of this title. The sums made available under this
21 section shall be used for making payments to States
22 which have submitted, and had approved by the Secretary
23 of Health, Education, and Welfare, State plans for medical
24 assistance.

1 “STATE PLANS FOR MEDICAL ASSISTANCE

2 “SEC. 1902. (a) A State plan for medical assistance
3 must—

4 “(1) provide that it shall be in effect in all political
5 subdivisions of the State, and, if administered by them,
6 be mandatory upon them;

7 “(2) provide for financial participation by the State
8 equal to not less than 40 per centum of the non-Federal
9 share of the expenditures under the plan with respect to
10 which payments under section 1903 are authorized by
11 this title; and, effective July 1, 1970, provide for
12 financial participation by the State equal to all of such
13 non-Federal share;

14 “(3) provide for granting an opportunity for a fair
15 hearing before the State agency to any individual whose
16 claim for medical assistance under the plan is denied or
17 is not acted upon with reasonable promptness;

18 “(4) provide such methods of administration (in-
19 cluding methods relating to the establishment and main-
20 tenance of personnel standards on a merit basis, except
21 that the Secretary shall exercise no authority with respect
22 to the selection, tenure of office, and compensation of any
23 individual employed in accordance with such methods,
24 and including provision for utilization of professional

1 medical personnel in the administration and, where ad-
2 ministered locally, supervision of administration of the
3 plan) as are found by the Secretary to be necessary for
4 the proper and efficient operation of the plan;

5 “(5) provide that the State agency administering
6 or supervising the administration of the plan of such
7 State approved under title I, or under title XVI (inso-
8 far as it relates to the aged), shall administer or super-
9 vise the administration of the plan for medical assist-
10 ance; and that any local agency administering the plan
11 of such State approved under title I, or under title XVI
12 (insofar as it relates to the aged), in a political sub-
13 division, shall administer the plan for medical assistance
14 in such subdivision;

15 “(6) provide that the State agency will make such
16 reports, in such form and containing such information,
17 as the Secretary may from time to time require, and
18 comply with such provisions as the Secretary may from
19 time to time find necessary to assure the correctness and
20 verification of such reports;

21 “(7) provide safeguards which restrict the use or
22 disclosure of information concerning applicants and
23 recipients to purposes directly connected with the admin-
24 istration of the plan;

25 “(8) provide that all individuals wishing to make

1 application for medical assistance under the plan shall
2 have opportunity to do so, and that such assistance shall
3 be furnished with reasonable promptness to all eligible
4 individuals;

5 “(9) provide for the establishment or designation
6 of a State authority or authorities which shall be respon-
7 sible for establishing and maintaining standards for
8 private or public institutions in which recipients of
9 medical assistance under the plan may receive care or
10 services;

11 “(10) provide for making medical assistance avail-
12 able to all individuals receiving aid or assistance under
13 State plans approved under titles I, IV, X, XIV, and
14 XVI; and—

15 “(A) provide that the medical assistance made
16 available to individuals receiving aid or assistance
17 under any such State plan—

18 “(i) shall not be less in amount, duration,
19 or scope than the medical assistance made avail-
20 able to individuals receiving aid or assistance
21 under any other such State plan, and

22 “(ii) shall not be less in amount, dura-
23 tion, or scope than the medical assistance made
24 available to individuals not receiving aid or
25 assistance under any such plan; and

1 “(B) if medical assistance is included for any
2 group of individuals who are not receiving aid or
3 assistance under any such State plan and who do not
4 meet the income and resources requirements of the
5 one of such State plans which is appropriate, as
6 determined in accordance with standards prescribed
7 by the Secretary, provide—

8 “(i) for making medical assistance avail-
9 able to all individuals who would, if needy, be
10 eligible for aid or assistance under any such
11 State plan and who have insufficient (as deter-
12 mined in accordance with comparable stand-
13 ards) income and resources to meet the costs of
14 necessary medical care and services, and

15 “(ii) that the medical assistance made
16 available to all individuals not receiving aid or
17 assistance under any such State plan shall be
18 equal in amount, duration, and scope;

19 “(11) provide for entering into cooperative arrange-
20 ments with the State agencies responsible for administer-
21 ing or supervising the administration of health services
22 and vocational rehabilitation services in the State looking
23 toward maximum utilization of such services in the
24 provision of medical assistance under the plan;

25 “(12) provide that, in determining whether an

1 individual is blind, there shall be an examination by a
2 physician skilled in the diseases of the eye or by an
3 optometrist, whichever the individual may select;

4 “(13) provide for inclusion of some institutional and
5 some noninstitutional care and services, and, effective
6 July 1, 1967, provide (A) for inclusion of at least the
7 care and services listed in clauses (1) through (5) of
8 section 1905(a), and (B) for payment of the reason-
9 able cost (as determined in accordance with standards
10 approved by the Secretary and included in the plan) of
11 inpatient hospital services provided under the plan;

12 “(14) provide that (A) no deduction, cost sharing,
13 or similar charge will be imposed under the plan on the
14 individual with respect to inpatient hospital services
15 furnished him under the plan, and (B) any deduction,
16 cost sharing, or similar charge imposed under the plan
17 with respect to any other medical assistance furnished
18 him thereunder, and any enrollment fee, premium, or
19 similar charge imposed under the plan, shall be reason-
20 ably related (as determined in accordance with stand-
21 ards approved by the Secretary and included in the
22 plan) to the recipient's income or his income and
23 resources;

24 “(15) in the case of eligible individuals 65 years

1 of age or older who are covered by either or both of
2 the insurance programs established by title XVIII,
3 provide—

4 “(A) for meeting the full cost of any deductible
5 imposed with respect to any such individual under
6 the insurance program established by part A of such
7 title; and

8 “(B) where, under the plan, all of any de-
9 ductible, cost sharing, or similar charge imposed
10 with respect to any such individual under the insur-
11 ance program established by part B of such title
12 is not met, the portion thereof which is met shall
13 be determined on a basis reasonably related (as
14 determined in accordance with standards approved
15 by the Secretary and included in the plan) to such
16 individual’s income or his income and resources;

17 “(16) provide for inclusion, to the extent required
18 by regulations prescribed by the Secretary, of provisions
19 (conforming to such regulations) with respect to the
20 furnishing of medical assistance under the plan to in-
21 dividuals who are residents of the State but are absent
22 therefrom;

23 “(17) include reasonable standards (which shall
24 be comparable for all groups) for determining eligibility
25 for and the extent of medical assistance under the plan

1 which (A) are consistent with the objectives of this
2 title, (B) provide for taking into account only such
3 income and resources as are, as determined in accord-
4 ance with standards prescribed by the Secretary, avail-
5 able to the applicant or recipient and (in the case of
6 any applicant or recipient who would, if he met the
7 requirements as to need, be eligible for aid or assistance
8 in the form of money payments under a State plan ap-
9 proved under title I, IV, X, XIV, or XVI) as would
10 not be disregarded (or set aside for future needs) in
11 determining his eligibility for and amount of such aid
12 or assistance under such plan, (C) provide for reason-
13 able evaluation of any such income or resources, and
14 (D) do not take into account the financial responsibility
15 of any individual for any applicant or recipient of assist-
16 ance under the plan unless such applicant or recipient
17 is such individual's spouse or such individual's child
18 who is under age 21 or is blind or permanently and
19 totally disabled; and provide for flexibility in the ap-
20 plication of such standards with respect to income by
21 taking into account, except to the extent prescribed
22 by the Secretary, the costs (whether in the form of
23 insurance premiums or otherwise) incurred for medical
24 care or for any other type of remedial care recognized
25 under State law;

1 “(18) provide that no lien may be imposed against
2 the property of any individual prior to his death on
3 account of medical assistance paid or to be paid on his
4 behalf under the plan (except pursuant to the judgment
5 of a court on account of benefits incorrectly paid on
6 behalf of such individual), and that there shall be no ad-
7 justment or recovery (except, in the case of an indi-
8 vidual who was 65 years of age or older when he received
9 such assistance, from his estate, and then only after the
10 death of his surviving spouse, if any, and only at a time
11 when he has no surviving child who is under age 21 or is
12 blind or permanently and totally disabled) of any medi-
13 cal assistance correctly paid on behalf of such individual
14 under the plan;

15 “(19) provide such safeguards as may be necessary
16 to assure that eligibility for care and services under the
17 plan will be determined, and such care and services will
18 be provided, in a manner consistent with simplicity of
19 administration and the best interests of the recipients;

20 “(20) if the State plan includes medical assistance
21 in behalf of individuals 65 years of age or older who are
22 patients in institutions for tuberculosis or mental
23 diseases—

24 “(A) provide for having in effect such agree-
25 ments or other arrangements with State authorities

1 concerned with mental diseases or tuberculosis (as
2 the case may be) , and, where appropriate, with such
3 institutions, as may be necessary for carrying out
4 the State plan, including arrangements for joint
5 planning and for development of alternate methods
6 of care, arrangements providing assurance of im-
7 mediate readmittance to institutions where needed
8 for individuals under alternate plans of care, and
9 arrangements providing for access to patients and
10 facilities, for furnishing information, and for making
11 reports;

12 “(B) provide for an individual plan for each
13 such patient to assure that the institutional care
14 provided to him is in his best interests, including, to
15 that end, assurances that there will be initial and
16 periodic review of his medical and other needs, that
17 he will be given appropriate medical treatment
18 within the institution, and that there will be a peri-
19 odical determination of his need for continued treat-
20 ment in the institution;

21 “(C) provide for the development of alternate
22 plans of care, making maximum utilization of avail-
23 able resources, for recipients 65 years of age or
24 older who would otherwise need care in such insti-
25 tutions, including appropriate medical treatment and

1 other aid or assistance; for services referred to in
2 section 3 (a) (4) (A) (i) and (ii) or section 1603
3 (a) (4) (A) (i) and (ii) which are appropriate
4 for such recipients and for such patients; and for
5 methods of administration necessary to assure that
6 the responsibilities of the State agency under the
7 State plan with respect to such recipients and such
8 patients will be effectively carried out; and

9 “(D) provide methods of determining the rea-
10 sonable cost of institutional care for such patients;
11 and

12 “(21) if the State plan includes medical assistance
13 in behalf of individuals 65 years of age or older who
14 are patients in public institutions for mental diseases,
15 show that the State is making satisfactory progress
16 toward developing and implementing a comprehensive
17 mental health program, including provision for utiliza-
18 tion of community mental health centers, nursing homes,
19 and other alternatives to care in public institutions for
20 mental diseases.

21 Notwithstanding paragraph (5), if on January 1, 1965, and
22 on the date on which a State submits its plan for approval
23 under this title, the State agency which administered or
24 supervised the administration of the plan of such State ap-
25 proved under title X (or title XVI, insofar as it relates

1 to the blind) was different from the State agency which
2 administered or supervised the administration of the State
3 plan approved under title I (or title XVI, insofar as it
4 relates to the aged), the State agency which administered
5 or supervised the administration of such plan approved under
6 title X (or title XVI, insofar as it relates to the blind)
7 may be designated to administer or supervise the administra-
8 tion of the portion of the State plan for medical assistance
9 which relates to blind individuals and the State agency
10 which administered or supervised the administration of such
11 plan approved under title I (or title XVI, insofar as it
12 relates to the aged) may be established or designated to
13 administer or supervise the administration of the rest of
14 the State plan for medical assistance; and in such case
15 the part of the plan which each such agency administers,
16 or the administration of which each such agency supervises,
17 shall be regarded as a separate plan for purposes of this
18 title (except for purposes of paragraph (10)).

19 “(b) The Secretary shall approve any plan which ful-
20 fills the conditions specified in subsection (a), except that
21 he shall not approve any plan which imposes, as a condition
22 of eligibility for medical assistance under the plan—

23 “(1) an age requirement of more than 65 years; or

24 “(2) effective July 1, 1967, any age requirement
25 which excludes any individual who has not attained the

1 age of 21 and is or would, except for the provisions of
2 section 406 (a) (2), be a dependent child under title
3 IV; or

4 “(3) any residence requirement which excludes any
5 individual who resides in the State; or

6 “(4) any citizenship requirement which excludes
7 any citizen of the United States.

8 “(c) Notwithstanding subsection (b), the Secretary
9 shall not approve any State plan for medical assistance if he
10 determines that the approval and operation of the plan will
11 result in a reduction in aid or assistance (other than so much
12 of the aid or assistance as is provided for under the plan of
13 the State approved under this title) provided for eligible in-
14 dividuals under a plan of such State approved under title I,
15 IV, X, XIV, or XVI.

16 “PAYMENT TO STATES

17 “SEC. 1903. (a) From the sums appropriated therefor,
18 the Secretary (except as otherwise provided in this section
19 and section 1117) shall pay to each State which has a plan
20 approved under this title, for each quarter, beginning with
21 the quarter commencing January 1, 1966—

22 “(1) an amount equal to the Federal medical
23 assistance percentage (as defined in section 1905 (b))
24 of the total amount expended during such quarter as
25 medical assistance under the State plan (including ex-

1 penditures for premiums under part B of title XVIII,
2 for individuals who are recipients of money payments
3 under a State plan approved under title I, IV, X, XIV,
4 or XVI, and other insurance premiums for medical or
5 any other type of remedial care or the cost thereof) ;
6 plus

7 “(2) an amount equal to 75 per centum of so much
8 of the sums expended during such quarter (as found
9 necessary by the Secretary for the proper and efficient
10 administration of the State plan) as are attributable to
11 compensation of skilled professional medical personnel,
12 and staff directly supporting such personnel, of the State
13 agency (or of the local agency administering the State
14 plan in the political subdivision) ; plus

15 “(3) an amount equal to 50 per centum of the
16 remainder of the amounts expended during such quarter
17 as found necessary by the Secretary for the proper and
18 efficient administration of the State plan.

19 “(b) Notwithstanding the preceding provisions of this
20 section, the amount determined under such provisions for
21 any State for any quarter which is attributable to expendi-
22 tures with respect to individuals 65 years of age or older who
23 are patients in institutions for tuberculosis or mental diseases
24 shall be paid only to the extent that the State makes a show-
25 ing satisfactory to the Secretary that total expendi-

1 tures from Federal, State, and local sources for men-
2 tal health services (including payments to or in behalf of
3 individuals with mental health problems) under State and
4 local public health and public welfare programs for such quar-
5 ter exceed the average of the total expenditures from such
6 sources for such services under such programs for each quar-
7 ter of the fiscal year ending June 30, 1965. For purposes of
8 this subsection, expenditures for such services for each quar-
9 ter in the fiscal year ending June 30, 1965, in the case of
10 any State shall be determined on the basis of the latest data,
11 satisfactory to the Secretary, available to him at the time of
12 the first determination by him under this subsection for such
13 State; and expenditures for such services for any quarter
14 beginning after December 31, 1965, in the case of any
15 State shall be determined on the basis of the latest data,
16 satisfactory to the Secretary, available to him at the time
17 of the determination under this subsection for such State for
18 such quarter; and determinations so made shall be conclusive
19 for purposes of this subsection.

20 “(c) (1) If the Secretary finds, on the basis of satisfac-
21 tory information furnished by a State, that the Federal med-
22 ical assistance percentage for such State applicable to any
23 quarter in the period beginning January 1, 1966, and ending
24 with the close of June 30, 1969, is less than 105 per centum
25 of the Federal share of medical expenditures by the State

1 during the fiscal year ending June 30, 1965 (as determined
 2 under paragraph (2)), then 105 per centum of such Federal
 3 share shall be the Federal medical assistance percentage (in-
 4 stead of the percentage determined under section 1905 (b))
 5 for such State for such quarter and each quarter thereafter
 6 occurring in such period and prior to the first quarter with
 7 respect to which such a finding is not applicable.

8 “(2) For purposes of paragraph (1) , the Federal share
 9 of medical expenditures by a State during the fiscal year
 10 ending June 30, 1965, means the percentage which the ex-
 11 cess of—

12 “(A) the total of the amounts determined under
 13 sections 3, 403, 1003, 1403, and 1603 with respect to
 14 expenditures by such State during such year as aid or
 15 assistance under its State plans approved under titles I,
 16 IV, X, XIV, and XVI, over

17 “(B) the total of the amounts which would have
 18 been determined under such sections with respect to
 19 such expenditures during such year if expenditures as aid
 20 or assistance in the form of medical or any other type of
 21 remedial care had not been counted,

22 is of the total expenditures as aid or assistance in the form
 23 of medical or any other type of remedial care under such
 24 plans during such year.

25 “(d) (1) Prior to the beginning of each quarter, the

1 Secretary shall estimate the amount to which a State will
2 be entitled under subsections (a), (b), and (c) for such
3 quarter, such estimates to be based on (A) a report filed by
4 the State containing its estimate of the total sum to be ex-
5 pended in such quarter in accordance with the provisions of
6 such subsections, and stating the amount appropriated or
7 made available by the State and its political subdivisions for
8 such expenditures in such quarter, and if such amount is less
9 than the State's proportionate share of the total sum of such
10 estimated expenditures, the source or sources from which
11 the difference is expected to be derived, and (B) such other
12 investigation as the Secretary may find necessary.

13 “(2) The Secretary shall then pay to the State, in
14 such installments as he may determine, the amount so esti-
15 mated, reduced or increased to the extent of any overpay-
16 ment or underpayment which the Secretary determines was
17 made under this section to such State for any prior quarter
18 and with respect to which adjustment has not already been
19 made under this subsection.

20 “(3) The pro rata share to which the United States is
21 equitably entitled, as determined by the Secretary, of the net
22 amount recovered during any quarter by the State or any
23 political subdivision thereof with respect to medical assistance
24 furnished under the State plan shall be considered an over-
25 payment to be adjusted under this subsection.

1 “(4) Upon the making of any estimate by the Secretary
2 under this subsection, any appropriations available for pay-
3 ments under this section shall be deemed obligated.

4 “(e) The Secretary shall not make payments under the
5 preceding provisions of this section to any State unless the
6 State makes a satisfactory showing that it is making efforts in
7 the direction of broadening the scope of the care and services
8 made available under the plan and in the direction of liberal-
9 izing the eligibility requirements for medical assistance, with
10 a view toward furnishing by July 1, 1975, comprehensive
11 care and services to substantially all individuals who meet
12 the plan’s eligibility standards with respect to income and
13 resources, including services to enable such individuals to
14 attain or retain independence or self-care.

15 “OPERATION OF STATE PLANS

16 “SEC. 1904. If the Secretary, after reasonable notice
17 and opportunity for hearing to the State agency administer-
18 ing or supervising the administration of the State plan
19 approved under this title, finds—

20 “(1) that the plan has been so changed that it no
21 longer complies with the provisions of section 1902; or

22 “(2) that in the administration of the plan there is
23 a failure to comply substantially with any such provision;
24 the Secretary shall notify such State agency that further
25 payments will not be made to the State (or, in his discretion,

1 that payments will be limited to categories under or parts of
 2 the State plan not affected by such failure), until the Secre-
 3 tary is satisfied that there will no longer be any such failure
 4 to comply. Until he is so satisfied he shall make no further
 5 payments to such State (or shall limit payments to categories
 6 under or parts of the State plan not affected by such failure).

7 "DEFINITIONS

8 "SEC. 1905. For purposes of this title—

9 "(a) The term 'medical assistance' means payment of
 10 part or all of the cost of the following care and services (if
 11 provided in or after the third month before the month in
 12 which the recipient makes application for assistance) for in-
 13 dividuals who, except for section 406 (a) (2), are (or would,
 14 if needy, be) dependent children under title IV (and are
 15 under the age of 21) or who are relatives specified in sec-
 16 tion 406 (b) (1) with whom such children are living, or who
 17 are 65 years of age or older, are blind, or are 18 years of
 18 age or older and permanently and totally disabled, but whose
 19 income and resources are insufficient to meet all of such
 20 cost—

21 "(1) inpatient hospital services;

22 "(2) outpatient hospital services;

23 "(3) other laboratory and X-ray services;

24 "(4) skilled nursing home services;

25 "(5) physicians' services, whether furnished in the

1 office, the patient's home, a hospital, or a skilled nursing
2 home, or elsewhere;

3 “(6) medical care, or any other type of remedial
4 care recognized under State law, furnished by licensed
5 practitioners within the scope of their practice as defined
6 by State law;

7 “(7) home health care services;

8 “(8) private duty nursing services;

9 “(9) clinic services;

10 “(10) dental services;

11 “(11) physical therapy and related services;

12 “(12) prescribed drugs, dentures, and prosthetic
13 devices; and eyeglasses prescribed by a physician skilled
14 in diseases of the eye or by an optometrist, whichever
15 the individual may select;

16 “(13) other diagnostic, screening, preventive, and
17 rehabilitative services; and

18 “(14) any other medical care, and any other type
19 of remedial care recognized under State law, specified
20 by the Secretary;

21 except that such term does not include—

22 “(A) any such payments with respect to care or
23 services for any individual who is an inmate of a public
24 institution (except as a patient in a medical institution) ;
25 or

1 “(B) any such payments with respect to care or
2 services for any individual who has not attained 65 years
3 of age and who is a patient in an institution for tubercu-
4 losis or mental diseases.

5 “(b) The term ‘Federal medical assistance percentage’
6 for any State shall be 100 per centum less the State per-
7 centage; and the State percentage shall be that percentage
8 which bears the same ratio to 45 per centum as the square
9 of the per capita income of such State bears to the square of
10 the per capita income of the continental United States (in-
11 cluding Alaska) and Hawaii; except that (1) the Federal
12 medical assistance percentage shall in no case be less than 50
13 per centum or more than 83 per centum, and (2) the Fed-
14 eral medical assistance percentage for Puerto Rico, the Vir-
15 gin Islands, and Guam shall be 55 per centum. The Federal
16 medical assistance percentage for any State shall be deter-
17 mined and promulgated in accordance with the provisions of
18 subparagraph (B) of section 1101 (a) (8) ; except that the
19 Secretary shall promulgate such percentage as soon as pos-
20 sible after the enactment of this title, which promulgation
21 shall be conclusive for each of the six quarters in the period
22 beginning January 1, 1966, and ending with the close of
23 June 30, 1967.”

24 (b) No payment may be made to any State under
25 title I, IV, X, XIV, or XVI of the Social Security Act

1 with respect to aid or assistance in the form of medical or
 2 any other type of remedial care for any period for which
 3 such State receives payments under title XIX of such Act,
 4 or for any period after June 30, 1967.

5 (c) (1) Effective January 1, 1966, section 1101 (a)
 6 (1) of the Social Security Act is amended by striking out
 7 “and XVI” and inserting in lieu thereof “XVI, and XIX”.

8 (2) Section 1109 of such Act is amended by adding at
 9 the end thereof the following new sentence: “Any amount
 10 which is disregarded (or set aside for future needs) in deter-
 11 mining eligibility for and amount of the aid or assistance for
 12 any individual under a State plan approved under title I,
 13 IV, X, XIV, XVI, or XIX shall not be taken into con-
 14 sideration in determining the eligibility for or amount of
 15 medical assistance for any other individual under a State
 16 plan approved under title XIX.”

17 (3) Effective January 1, 1966, section 1115 of such
 18 Act is amended by striking out “or XVI”, “or 1602”, and
 19 “or 1603” and inserting in lieu thereof “XVI, or XIX”,
 20 “1602, or 1902”, and “1603, or 1903”, respectively.

21 PAYMENT BY STATES OF PREMIUMS FOR SUPPLEMENTARY
 22 HEALTH INSURANCE

23 SEC. 122. Sections 3 (a), 403 (a), 1003 (a), 1403 (a),
 24 and 1603 (a) of the Social Security Act are each amended

1 by inserting “premiums under part B of title XVIII for in-
 2 dividuals who are recipients of money payments under such
 3 plan and other” after “expenditures for” in the parenthetical
 4 phrase appearing in so much of paragraph (1) thereof as
 5 precedes clause (A).

6 TITLE II—OTHER AMENDMENTS RELATING TO
 7 HEALTH CARE

8 PART 1—MATERNAL AND CHILD HEALTH AND CRIPPLED
 9 CHILDREN’S SERVICES

10 INCREASE IN MATERNAL AND CHILD HEALTH SERVICES

11 SEC. 201. (a) The first sentence of section 501 of
 12 the Social Security Act is amended by striking out
 13 “\$40,000,000” and all that follows and inserting in lieu
 14 thereof “\$45,000,000 for the fiscal year ending June 30,
 15 1966, \$50,000,000 for the fiscal year ending June 30, 1967,
 16 \$55,000,000 for the fiscal year ending June 30, 1968,
 17 \$55,000,000 for the fiscal year ending June 30, 1969, and
 18 \$60,000,000 for the fiscal year ending June 30, 1970, and
 19 succeeding fiscal years.”

20 (b) Section 504 of such Act is amended by adding at
 21 the end thereof the following new subsection:

22 “(d) Notwithstanding the preceding provisions of this
 23 section, no payment shall be made to any State thereunder
 24 for any period after June 30, 1966, unless it makes a satis-

1 factory showing that the State is extending the provision of
2 maternal and child health services in the State with a view
3 to making such services available by July 1, 1975, to
4 children in all parts of the State.”

5 INCREASE IN CRIPPLED CHILDREN’S SERVICES

6 SEC. 202. (a) The first sentence of section 511 of the
7 Social Security Act is amended by striking out “\$40,-
8 000,000” and all that follows and inserting in lieu thereof
9 “\$45,000,000 for the fiscal year ending June 30, 1966,
10 \$50,000,000 for the fiscal year ending June 30, 1967,
11 \$55,000,000 for the fiscal year ending June 30, 1968,
12 \$55,000,000 for the fiscal year ending June 30, 1969, and
13 \$60,000,000 for the fiscal year ending June 30, 1970, and
14 succeeding fiscal years.”

15 (b) Section 514 of such Act is amended by adding at
16 the end thereof the following new subsection:

17 “(d) Notwithstanding the preceding provisions of this
18 subsection, no payment shall be made to any State there-
19 under for any period after June 30, 1966, unless it makes
20 a satisfactory showing that the State is extending the pro-
21 vision of crippled children’s services in the State with a
22 view to making such services available by July 1, 1975, to
23 children in all parts of the State.”

1 TRAINING OF PROFESSIONAL PERSONNEL FOR THE CARE OF
2 CRIPPLED CHILDREN

3 SEC. 203. (a) Part 2 of title V of the Social Security
4 Act is amended by adding at the end thereof the following
5 new section:

6 "TRAINING OF PROFESSIONAL PERSONNEL

7 “SEC. 516. There are authorized to be appropriated
8 \$5,000,000 for the fiscal year ending June 30, 1967, \$10,-
9 000,000 for the fiscal year ending June 30, 1968, and
10 \$17,500,000 for each fiscal year thereafter, for grants by the
11 Secretary to public or other nonprofit institutions of higher
12 learning for training professional personnel for health and
13 related care of crippled children, particularly mentally re-
14 tarded children and children with multiple handicaps.”

15 (b) The second sentence of section 514 (c) of such Act
16 is amended by striking out “section 512 (b)” and inserting
17 in lieu thereof “section 512 (b) or 516”.

18 PAYMENT FOR INPATIENT HOSPITAL SERVICES

SEC. 204. (a) Section 503 (a) of the Social Security Act is amended by striking out "and" before clause (7) and by inserting before the period at the end thereof the following new clause: "; and (8) effective July 1, 1967, provide for payment of the reasonable cost (as determined in accordance with standards approved by the Secretary and included

1 in the plan) of inpatient hospital services provided under the
2 plan”.

3 (b) Section 513 (a) of such Act is amended by striking
4 out “and” before clause (6) and by inserting before the pe-
5 riod at the end thereof the following new clause: “; and (7)
6 effective July 1, 1967, provide for payment of the reason-
7 able cost (as determined in accordance with standards ap-
8 proved by the Secretary and included in the plan) of
9 inpatient hospital services provided under the plan”.

10 SPECIAL PROJECT GRANTS FOR HEALTH OF SCHOOL AND
11 PRESCHOOL CHILDREN

12 SEC. 205. Part 4 of title V of the Social Security Act is
13 amended (1) by revising the heading thereof to read as
14 follows: “PART 4—GRANTS FOR SPECIAL MATERNITY AND
15 INFANT CARE PROJECTS, FOR PROJECTS FOR HEALTH OF
16 SCHOOL AND PRESCHOOL CHILDREN, AND FOR RESEARCH
17 PROJECTS”; (2) by redesignating section 532 as section
18 533; and (3) by inserting after section 531 the following
19 new section:

20 “SPECIAL PROJECT GRANTS FOR HEALTH OF SCHOOL AND
21 PRESCHOOL CHILDREN

22 “SEC. 532. (a) In order to promote the health of chil-
23 dren and youth of school or preschool age, particularly in
24 areas with concentrations of low-income families, there are

1 authorized to be appropriated \$15,000,000 for the fiscal year
2 ending June 30, 1966, \$35,000,000 for the fiscal year end-
3 ing June 30, 1967, \$40,000,000 for the fiscal year ending
4 June 30, 1968, \$45,000,000 for the fiscal year ending June
5 30, 1969, and \$50,000,000 for the fiscal year ending June
6 30, 1970, for grants as provided in this section.

7 “(b) From the sums appropriated pursuant to subsec-
8 tion (a), the Secretary is authorized to make grants to
9 the State health agency of any State and (with the consent
10 of such agency) to the health agency of any political sub-
11 division of the State, to the State agency of the State admin-
12 istering or supervising the administration of the State plan
13 approved under section 513, to any school of medicine (with
14 appropriate participation by a school of dentistry), and
15 to any teaching hospital affiliated with such a school, to pay
16 not to exceed 75 per centum of the cost of projects of a
17 comprehensive nature for health care and services for chil-
18 dren and youth of school age or for preschool children (to
19 help them prepare to start school). No project shall be
20 eligible for a grant under this section unless it provides
21 (1) for the coordination of health care and services pro-
22 vided under it with, and utilization (to the extent feasible)
23 of, other State or local health, welfare, and education pro-
24 grams for such children, (2) for payment of the reasonable
25 cost (as determined in accordance with standards approved

1 by the Secretary) of inpatient hospital services provided
2 under the project, and (3) that any treatment, correction
3 of defects, or aftercare provided under the project is avail-
4 able only to children who would not otherwise receive it
5 because they are from low-income families or for other
6 reasons beyond their control; and no such project for chil-
7 dren and youth of school age shall be considered to be of a
8 comprehensive nature for purposes of this section unless it
9 includes (subject to the limitation in the preceding provi-
10 sions of this sentence) at least such screening, diagnosis,
11 preventive services, treatment, correction of defects, and
12 aftercare, both medical and dental, as may be provided
13 for in regulations of the Secretary.

14 “(c) Payment of grants under this section may be
15 made (after necessary adjustment on account of previously
16 made underpayments or overpayments) in advance or by
17 way of reimbursement, and in such installments and on such
18 conditions, as the Secretary may determine.”

19 EVALUATION AND REPORT

20 SEC. 206. The Secretary shall submit to the President
21 for transmission to the Congress before July 1, 1969, a full
22 report of the administration of the provisions of section 532
23 of the Social Security Act (as added by section 205 of this
24 Act), together with an evaluation of the program established

1 thereby and his recommendations as to continuation of
2 and modifications in that program.

3 PART 2—IMPLEMENTATION OF MENTAL RETARDATION

4 PLANNING

5 AUTHORIZATION OF APPROPRIATIONS

6 SEC. 211. (a) Section 1701 of the Social Security Act
7 is amended by adding at the end thereof the following new
8 sentence: "There are also authorized to be appropriated,
9 for assisting such States in initiating the implementation and
10 carrying out of planning and other steps to combat mental
11 retardation, \$2,750,000 for the fiscal year ending June 30,
12 1966, and \$2,750,000 for the fiscal year ending June 30,
13 1967."

14 (b) The first sentence of section 1702 of such Act is
15 amended by inserting "the first sentence of" before "section
16 1701" and by inserting the following before the period at
17 the end thereof "; and the sums appropriated pursuant to
18 the second sentence of such section for the fiscal year ending
19 June 30, 1966, shall be available for such grants during such
20 year and the next two fiscal years, and sums appropriated
21 pursuant thereto for the fiscal year ending June 30, 1967,
22 shall be available for such grants during such year and the
23 succeeding fiscal year".

1 PART 3—PUBLIC ASSISTANCE AMENDMENTS RELATING
2 TO HEALTH CARE

3 REMOVAL OF LIMITATIONS ON FEDERAL PARTICIPATION IN
4 ASSISTANCE TO AGED INDIVIDUALS WITH TUBERCULO-
5 SIS OR MENTAL DISEASE

6 SEC. 221. (a) (1) Section 6 (a) of the Social Security
7 Act is amended to read as follows:

8 “(a) For the purposes of this title, the term ‘old-age
9 assistance’ means money payments to, or (if provided in
10 or after the third month before the month in which the
11 recipient makes application for assistance) medical care in
12 behalf of or any type of remedial care recognized under State
13 law in behalf of, needy individuals who are 65 years of
14 age or older, but does not include any such payments to
15 or care in behalf of any individual who is an inmate of a
16 public institution (except as a patient in a medical institu-
17 tion).”

18 (2) Section 6 (b) of such Act is amended by striking
19 out all that follows clause (12) and inserting in lieu thereof
20 the following:

21 “except that such term does not include any such payments
22 with respect to care or services for any individual who is
23 an inmate of a public institution (except as a patient in a
24 medical institution).”

1 (3) Section 2 (a) of such Act is amended (A) by
2 striking out “and” at the end of paragraph (10); (B) by
3 striking out the period at the end of paragraph (11) and
4 inserting in lieu thereof a semicolon; and (C) by adding
5 after paragraph (11) the following new paragraphs:

6 “(12) if the State plan includes assistance to or in
7 behalf of individuals who are patients in institutions for
8 tuberculosis or mental diseases—

9 “(A) provide for having in effect such agree-
10 ments or other arrangements with State authorities
11 concerned with mental diseases or tuberculosis (as
12 the case may be), and, where appropriate, with
13 such institutions, as may be necessary for carrying
14 out the State plan, including arrangements for joint
15 planning and for development of alternate methods
16 of care, arrangements providing assurance of im-
17 mediate readmittance to institutions where needed
18 for individuals under alternate plans of care, and
19 arrangements providing for access to patients and
20 facilities, for furnishing information, and for making
21 reports;

22 “(B) provide for an individual plan for each
23 such patient to assure that the institutional care

1 provided to him is in his best interests, including,
2 to that end, assurances that there will be initial
3 and periodic review of his medical and other needs,
4 that he will be given appropriate medical treat-
5 ment within the institution, and that there will be a
6 periodic determination of his need for continued
7 treatment in the institution;

8 “(C) provide for the development of alternate
9 plans of care, making maximum utilization of avail-
10 able resources, for recipients who would otherwise
11 need care in such institutions, including appropriate
12 medical treatment and other assistance; for services
13 referred to in section 3 (a) (4) (A) (i) and (ii)
14 which are appropriate for such recipients and for
15 such patients; and for methods of administration
16 necessary to assure that the responsibilities of the
17 State agency under the State plan with respect to
18 such recipients and such patients will be effectively
19 carried out; and

20 “(D) provide methods of determining the rea-
21 sonable cost of institutional care for such patients;
22 and

23 “(13) if the State plan includes assistance to or
24 in behalf of patients in public institutions for mental
25 diseases, show that the State is making satisfactory

1 progress toward developing and implementing a com-
2 prehensive mental health program, including provision
3 for utilization of community mental health centers, nurs-
4 ing homes, and other alternatives to care in public in-
5 stitutions for mental diseases.”

6 (4) Section 3 of such Act is amended by adding at
7 the end thereof the following new subsection:

8 “(d) Notwithstanding the preceding provisions of this
9 section, the amount determined under such provisions for
10 any State for any quarter which is attributable to expendi-
11 tures with respect to patients in institutions for tuberculosis
12 or mental diseases shall be paid only to the extent that
13 the State makes a showing satisfactory to the Secretary that
14 total expenditures in the State from Federal, State, and local
15 sources for mental health services (including payments to or
16 in behalf of individuals with mental health problems) under
17 State and local public health and public welfare programs
18 for such quarter exceed the average of the total expenditures
19 in the State from such sources for such services under such
20 programs for each quarter of the fiscal year ending June 30,
21 1965. For purposes of this subsection, expenditures for such
22 services for each quarter in the fiscal year ending June 30,
23 1965, in the case of any State shall be determined on the
24 basis of the latest data, satisfactory to the Secretary, avail-
25 able to him at the time of the first determination by him

1 under this subsection for such State; and expenditures for
2 such services for any quarter beginning after December 31,
3 1965, in the case of any State shall be determined on the
4 basis of the latest data, satisfactory to the Secretary, available
5 to him at the time of the determination under this subsection
6 for such State for such quarter; and determinations so made
7 shall be conclusive for purposes of this subsection.”

8 (b) Section 1006 of such Act is amended by striking
9 out clauses (a) and (b) and inserting in lieu thereof the
10 following: “who is a patient in an institution for tuberculosis
11 or mental diseases”.

12 (c) Section 1405 of such Act is amended by striking
13 out clauses (a) and (b) and inserting in lieu thereof the
14 following: “who is a patient in an institution for tuberculosis
15 or mental diseases”.

16 (d) (1) Section 1605 (a) of such Act is amended to
17 read as follows:

18 “(a) For purposes of this title, the term ‘aid to the
19 aged, blind, or disabled’ means money payments to, or (if
20 provided in or after the third month before the month in
21 which the recipient makes application for aid) medical care
22 in behalf of or any type of remedial care recognized under
23 State law in behalf of, needy individuals who are 65 years
24 of age or older, are blind, or are 18 years of age or over

1 and permanently and totally disabled, but such term does not
2 include—

3 “(1) any such payments to or care in behalf of any
4 individual who is an inmate of a public institution (ex-
5 cept as a patient in a medical institution) ; or

6 “(2) any such payments to or care in behalf of
7 any individual who has not attained 65 years of age
8 and who is a patient in an institution for tuberculosis
9 or mental diseases.”

10 (2) Section 1605 (b) of such Act is amended by strik-
11 ing out all that follows clause (12) and inserting in lieu
12 thereof the following:

13 “except that such term does not include any such payments
14 with respect to care or services for any individual who is an
15 inmate of a public institution (except as a patient in a medi-
16 cal institution).”

17 (3) Section 1602 (a) of such Act is amended (A) by
18 striking out “and” at the end of paragraph (14) ; (B) by
19 striking out the period at the end of paragraph (15) and
20 inserting in lieu thereof a semicolon; and (C) by adding
21 after paragraph (15) the following new paragraphs:

22 “(16) if the State plan includes aid or assistance
23 to or in behalf of individuals 65 years of age or older who
24 are patients in institutions for tuberculosis or mental
25 diseases—

1 “(A) provide for having in effect such agree-
2 ments or other arrangements with State authorities
3 concerned with mental diseases or tuberculosis (as
4 the case may be), and, where appropriate, with such
5 institutions, as may be necessary for carrying out
6 the State plan, including arrangements for joint
7 planning and for development of alternate methods
8 of care, arrangements providing assurance of im-
9 mediate readmittance to institutions where needed
10 for individuals under alternate plans of care, and
11 arrangements providing for access to patients and
12 facilities, for furnishing information, and for making
13 reports;

14 “(B) provide for an individual plan for each
15 such patient to assure that the institutional care pro-
16 vided to him is in his best interests, including, to
17 that end, assurances that there will be initial and
18 periodic review of his medical and other needs, that
19 he will be given appropriate medical treatment
20 within the institution, and that there will be a
21 periodic determination of his need for continued
22 treatment in the institution;

23 “(C) provide for the development of alternate
24 plans of care, making maximum utilization of avail-
25 able resources, for recipients 65 years of age or older

1 who would otherwise need care in such institutions,
2 including appropriate medical treatment and other
3 aid or assistance; for services referred to in section
4 1603 (a) (4) (A) (i) and (ii) which are appro-
5 priate for such recipients and for such patients; and
6 for methods of administration necessary to assure
7 that the responsibilities of the State agency under
8 the State plan with respect to such recipients and
9 such patients will be effectively carried out; and

10 “(D) provide methods of determining the rea-
11 sonable cost of institutional care for such patients;
12 and

13 “(17) if the State plan includes aid or assistance to
14 or in behalf of individuals 65 years of age or older who
15 are patients in public institutions for mental diseases,
16 show that the State is making satisfactory progress
17 toward developing and implementing a comprehensive
18 mental health program, including provision for utiliza-
19 tion of community mental health centers, nursing homes,

1 and other alternatives to care in public institutions for
2 mental diseases.”

3 (4) Section 1603 of such Act is amended by adding at
4 the end thereof the following new subsection:

5 “(d) Notwithstanding the preceding provisions of this
6 section, the amount determined under such provisions for any
7 State for any quarter which is attributable to expenditures
8 with respect to individuals 65 years of age or older who are
9 patients in institutions for tuberculosis or mental diseases
10 shall be paid only to the extent that the State makes a show-
11 ing satisfactory to the Secretary that total expenditures in
12 the State from Federal, State, and local sources for mental
13 health services (including payments to or in behalf of indi-
14 viduals with mental health problems) under State and local
15 public health and public welfare programs for such quarter
16 exceed the average of the total expenditures in the State
17 from such sources for such services under such programs for
18 each quarter of the fiscal year ending June 30, 1965. For

1 purposes of this subsection, expenditures for such services
 2 for each quarter in the fiscal year ending June 30, 1965,
 3 in the case of any State shall be determined on the basis
 4 of the latest data, satisfactory to the Secretary, available to
 5 him at the time of the first determination by him under this
 6 subsection for such State; and expenditures for such services
 7 for any quarter beginning after December 31, 1965, in the
 8 case of any State shall be determined on the basis of the
 9 latest data, satisfactory to the Secretary, available to him at
 10 the time of the determination under this subsection for such
 11 State for such quarter; and determinations so made shall be
 12 conclusive for purposes of this subsection."

13 (e) The amendments made by this section shall apply
 14 in the case of expenditures made after December 31, 1965,
 15 under a State plan approved under title I, X, XIV, or XVI
 16 of the Social Security Act.

17 AMENDMENT TO DEFINITION OF MEDICAL ASSISTANCE FOR

18 THE AGED

19 SEC. 222. (a) Section 6 (b) of the Social Security Act
 20 is amended by striking out "who are not recipients of old-age
 21 assistance" and inserting in lieu thereof "who are not re-
 22 cipients of old-age assistance (except, for any month, for
 23 recipients of old-age assistance who are admitted to or dis-

1 charged from a medical institution during such month)".

2 (b) Section 1605 (b) of such Act is amended by strik-
 3 ing out "who are not recipients of aid to the aged, blind,
 4 or disabled" and inserting in lieu thereof "who are not re-
 5 cipients of aid to the aged, blind, or disabled (except, for
 6 any month, for recipients of aid to the aged, blind, or dis-
 7 abled who are admitted to or discharged from a medical in-
 8 stitution during such month)".

9 (c) The amendments made by this section shall apply
 10 in the case of expenditures under a State plan approved
 11 under title I or XVI of the Social Security Act with respect
 12 to care and services provided under such plan after
 13 June 1965.

14 TITLE III—SOCIAL SECURITY AMENDMENTS

15 SHORT TITLE

16 SEC. 300. This title may be cited as the "Old-Age, Sur-
 17 vivors, and Disability Insurance Amendments of 1965".

18 INCREASE IN OLD-AGE, SURVIVORS, AND DISABILITY

19 INSURANCE BENEFITS

20 SEC. 301. (a) Section 215 (a) of the Social Security
 21 Act is amended by striking out the table and inserting in
 22 lieu thereof the following:

"TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND MAXIMUM FAMILY BENEFITS

I (Primary insurance benefit under 1939 Act, as modified)		II (Primary insurance amount under 1958 Act, as modified)	III (Average monthly wage)		IV (Primary insurance amount)	V (Maximum family benefits)
If an individual's primary insurance benefit (as determined under subsec. (d)) is—		Or his primary insurance amount (as determined under subsec. (c)) is—	Or his average monthly wage (as determined under subsec. (b)) is—		The amount referred to in the preceding paragraphs of this subsection shall be—	And the maximum amount of benefits payable (as provided in sec. 203(a)) on the basis of his wages and self-employment income shall be—
At least—	But not more than—		At least—	But not more than—		
-----	\$13.48	\$40	---	\$67	\$44.00	\$66.00
\$13.49	14.00	41	\$68	69	45.00	67.50
14.01	14.48	42	70	70	46.00	69.00
14.49	15.00	43	71	72	47.00	70.50
15.01	15.60	44	73	74	48.00	72.00
15.61	16.20	45	75	76	49.00	73.50
16.21	16.84	46	77	78	50.00	75.00
16.85	17.60	47	79	80	51.00	76.50
17.61	18.40	48	81	81	52.00	78.00
18.41	19.24	49	82	83	53.00	79.50
19.25	20.00	50	84	85	54.00	81.00
20.01	20.64	51	86	87	55.00	82.50
20.65	21.28	52	88	89	56.00	84.00
21.29	21.88	53	90	90	57.00	85.50
21.89	22.28	54	91	92	58.00	87.00
22.29	22.68	55	93	94	59.00	88.50
22.69	23.08	56	95	96	60.00	90.00
23.09	23.44	57	97	97	61.00	91.50
23.45	23.76	58	98	99	62.10	93.20
23.77	24.20	59	100	101	63.20	94.80
24.21	24.60	60	102	102	64.20	96.30
24.61	25.00	61	103	104	65.30	98.00
25.01	25.48	62	105	106	66.40	99.60
25.49	25.92	63	107	107	67.50	101.30
25.93	26.40	64	108	109	68.50	102.80
26.41	26.94	65	110	113	69.60	104.40
26.95	27.46	66	114	118	70.70	106.10
27.47	28.00	67	119	122	71.70	107.60
28.01	28.68	68	123	127	72.80	109.20
28.69	29.25	69	128	132	73.90	110.90
29.26	29.88	70	133	136	74.90	112.40
29.89	30.36	71	137	141	76.00	114.00
30.37	30.92	72	142	146	77.10	116.80
30.93	31.36	73	147	150	78.20	120.00
31.37	32.00	74	151	155	79.20	124.00
32.01	32.60	75	156	160	80.30	128.00
32.61	33.20	76	161	164	81.40	131.20
33.21	33.88	77	165	169	82.40	135.20
33.89	34.50	78	170	174	83.50	139.20
34.51	35.00	79	175	178	84.60	142.40
35.01	35.80	80	179	183	85.60	146.40
35.81	36.40	81	184	188	86.70	150.40
36.41	37.08	82	189	193	87.80	154.40
37.09	37.60	83	194	197	88.90	157.60
37.61	38.20	84	198	202	89.90	161.60
38.21	39.12	85	203	207	91.00	165.60
39.13	39.68	86	208	211	92.10	168.80
39.69	40.33	87	212	216	93.10	172.80
40.34	41.12	88	217	221	94.20	176.80
41.13	41.76	89	222	225	95.30	180.00
41.77	42.44	90	226	230	96.30	184.00
42.45	43.20	91	231	235	97.40	188.00
43.21	43.76	92	236	239	98.50	191.20
43.77	44.44	93	240	244	99.60	195.20
44.45	44.88	94	245	249	100.60	199.20
44.89	45.60	95	250	253	101.70	202.40
		96	254	258	102.80	206.40
		97	259	263	103.80	210.40
		98	264	267	104.90	213.60
		99	268	272	106.00	217.60
		100	273	277	107.00	221.60
		101	278	281	108.10	224.80
		102	282	286	109.20	228.80
		103	287	291	110.30	232.80
		104	292	295	111.30	236.00
		105	296	300	112.40	240.00
		106	301	305	113.50	244.00
		107	306	309	114.50	247.20
		108	310	314	115.60	251.20
		109	315	319	116.70	254.00
		110	320	323	117.70	254.80
		111	324	328	118.80	256.80
		112	329	333	119.90	258.80
		113	334	337	121.00	260.40

"TABLE FOR DETERMINING PRIMARY INSURANCE AMOUNT AND MAXIMUM FAMILY BENEFITS—Continued

"I (Primary insurance benefit under 1939 Act, as modified)		II (Primary insurance amount under 1958 Act, as modified)	III (Average monthly wage)		IV (Primary insurance amount)	V (Maximum family benefits)
If an individual's primary insurance benefit (as determined under subsec. (d)) is—		Or his primary insurance amount (as determined under subsec. (e)) is—	Or his average monthly wage (as determined under subsec. (b)) is—		The amount referred to in the preceding paragraphs of this subsection shall be—	And the maximum amount of benefits payable as provided in sec. 203(a) on the basis of his wages and self-employment income shall be—
At least—	But not more than—		At least—	But not more than—		
		\$114	\$338	\$342	\$122.00	\$262.40
		115	343	347	123.10	264.40
		116	348	351	124.20	266.00
		117	352	356	125.20	268.00
		118	357	361	126.30	270.00
		119	362	365	127.40	271.60
		120	366	370	128.40	273.60
		121	371	375	129.50	275.60
		122	376	379	130.60	277.20
		123	380	384	131.70	279.20
		124	385	389	132.70	281.20
		125	390	393	133.80	282.80
		126	394	398	134.90	284.80
		127	399	403	135.90	286.80
			404	407	136.90	288.40
			408	412	137.90	290.40
			413	417	138.90	292.40
			418	421	139.90	294.00
			422	426	140.90	296.00
			427	431	141.90	298.00
			432	436	142.90	300.00
			437	440	143.90	301.60
			441	445	144.90	303.60
			446	450	145.90	305.60
			451	454	146.90	307.20
			455	459	147.90	309.20
			460	464	148.90	311.20
			465	469	149.90	312.00"

1 (b) Section 215(c) of such Act is amended to read
2 as follows:
3 "Primary Insurance Amount Under 1958 Act, as Modified
4 "(c) (1) For the purposes of column II of the table
5 appearing in subsection (a) of this section, an individual's
6 primary insurance amount shall be computed as provided in,
7 and subject to the limitations specified in, (A) this section
8 as in effect prior to the enactment of the Social Security
9 Amendments of 1965, and (B) the applicable provisions
10 of the Social Security Amendments of 1960.

1 “(2) The provisions of this subsection shall be appli-
2 cable only in the case of an individual who became entitled
3 to benefits under section 202 (a) or section 223 before the
4 date of enactment of the Social Security Amendments of
5 1965 or who died before such date.”

6 (c) Section 203 (a) of such Act is amended by strik-
7 ing out paragraphs (2) and (3) and inserting in lieu thereof
8 the following:

9 “(2) when two or more persons were entitled
10 (without the application of section 202 (j) (1) and sec-
11 tion 223 (b)) to monthly benefits under section 202 or
12 223 for any month which begins after December 1964
13 and before the enactment of the Social Security Amend-
14 ments of 1965, on the basis of the wages and self-
15 employment income of such insured individual, such
16 total of benefits for any month occurring after December
17 1964 shall not be reduced to less than the larger of—

18 “(A) the amount determined under this sub-
19 section without regard to this paragraph, or

20 “(B) (i) with respect to the month in which
21 such Amendments are enacted or any prior month,
22 an amount equal to the sum of the amounts derived
23 by multiplying the benefit amount determined under
24 this title (including this subsection, but without the
25 application of section 222 (b) , section 202 (q) , and

1 subsections (b), (c), and (d) of this section), as in
2 effect prior to the enactment of such Amendments,
3 for each such person, for such month, by 107 per-
4 cent and raising each such increased amount, if it
5 is not a multiple of \$0.10, to the next higher
6 multiple of \$0.10, and

7 “(ii) with respect to any month after the
8 month in which such Amendments are enacted, an
9 amount equal to the sum of the amounts derived by
10 multiplying the benefit amount determined under
11 this title (including this subsection, but without the
12 application of section 222 (b), section 202 (q), and
13 subsections (b), (c), and (d) of this section), as in
14 effect prior to the enactment of such Amendments,
15 for each such person for the month of enactment,
16 by 107 percent and raising each such increased
17 amount, if it is not a multiple of \$0.10, to the next
18 higher multiple of \$0.10;

19 but in any such case (I) paragraph (1) of this sub-
20 section shall not be applied to such total of benefits after
21 the application of subparagraph (B) of this paragraph,
22 and (II) if section 202 (k) (2) (A) was applicable in
23 the case of any of such benefits for any such month
24 beginning before the enactment of the Social Security
25 Amendments of 1965, and ceases to apply after such

1 month, the provisions of subparagraph (B) shall be
2 applied, for and after the month in which such section
3 202 (k) (2) (A) ceases to apply, as though paragraph
4 (1) had not been applicable to such total of benefits for
5 such month beginning prior to such enactment.”

6 (d) The amendments made by subsections (a), (b),
7 and (c) of this section shall apply with respect to monthly
8 benefits under title II of the Social Security Act for months
9 after December 1964 and with respect to lump-sum death
10 payments under such title in the case of deaths occurring in
11 or after the month in which this Act is enacted.

12 (e) If an individual is entitled to a disability insurance
13 benefit under section 223 of the Social Security Act for De-
14 cember 1964 on the basis of an application filed after enact-
15 ment of this Act and is entitled to old-age insurance benefits
16 under section 202 (a) of such Act for January 1965, then,
17 for purposes of section 215 (a) (4) of the Social Security
18 Act (if applicable) the amount in column IV of the table
19 appearing in such section 215 (a) for such individual shall
20 be the amount in such column on the line on which in column
21 II appears his primary insurance amount (as determined
22 under section 215 (c) of such Act) instead of the amount
23 in column IV equal to his disability insurance benefit.

24 (f) Effective with respect to monthly benefits under
25 title II of the Social Security Act for months after 1970

1 and with respect to lump-sum death payments under such
 2 title in the case of deaths occurring after such year, the table
 3 in section 215(a) of such Act (as amended by subsection
 4 (a) of this section) is amended by striking out all figures in
 5 columns II, III, IV, and V beginning with the line which
 6 reads

	"109	315	319	116.70	254.00"
--	------	-----	-----	--------	---------

7 and down through the line which reads

	"465	466	149.90	312.00"
--	------	-----	--------	---------

8 and inserting in lieu thereof the following:

	"109	315	319	116.70	255.20
	110	320	323	117.70	256.40
	111	324	326	118.80	257.60
	112	329	333	119.90	258.80
	113	334	337	121.00	259.60
	114	338	342	122.00	273.60
	115	343	347	123.10	277.60
	116	348	351	124.20	280.80
	117	352	356	125.20	284.80
	118	357	361	126.30	288.80
	119	362	365	127.40	292.00
	120	366	370	128.40	296.00
	121	371	375	129.50	298.00
	122	375	379	130.60	299.60
	123	380	384	131.70	301.60
	124	385	389	132.70	303.60
	125	390	393	133.80	305.20
	126	394	398	134.90	307.20
	127	399	406	135.90	309.20
	404	407	136.90	311.20	311.20
	408	412	137.90	312.80	312.80
	413	417	138.90	314.80	314.80
	415	421	139.90	316.40	316.40
	422	426	140.90	318.40	318.40
	427	431	141.90	320.40	320.40
	432	436	142.90	322.40	322.40
	437	440	143.90	324.00	324.00
	441	445	144.90	326.00	326.00
	446	450	145.90	328.00	328.00
	451	454	146.90	329.60	329.60
	455	459	147.90	331.60	331.60
	460	464	148.90	333.60	333.60
	465	468	149.90	335.20	335.20
	469	473	150.90	337.20	337.20
	474	478	151.90	339.20	339.20
	479	482	152.90	341.20	341.20
	483	487	153.90	342.80	342.80
	488	492	154.90	344.80	344.80
	493	496	155.90	346.40	346.40
	497	501	156.90	348.40	348.40
	502	506	157.90	350.40	350.40
	507	510	158.90	352.00	352.00
	511	515	159.90	354.00	354.00
	516	520	160.90	356.00	356.00
	521	524	161.90	357.60	357.60
	525	529	162.90	359.60	359.60
	530	534	163.90	361.60	361.60
	535	538	164.90	363.20	363.20
	539	543	165.90	365.20	365.20
	544	548	166.90	367.20	367.20
	549	550	167.90	368.00"	368.00"

1 COMPUTATION AND RECOMPUTATION OF BENEFITS

2 SEC. 302. (a) (1) Subparagraph (C) of section 215
3 (b) (2) of the Social Security Act is amended to read as
4 follows:

5 “(C) For purposes of subparagraph (B), ‘computation
6 base years’ include only calendar years in the period after
7 1950 and prior to the earlier of the following years—

8 “(i) the year in which occurred (whether by
9 reason of section 202(j) (1) or otherwise) the first
10 month for which the individual was entitled to old-age
11 insurance benefits, or

12 “(ii) the year succeeding the year in which he died.
13 Any calendar year all of which is included in a period of
14 disability shall not be included as a computation base year.”

15 (2) Clauses (A), (B), and (C) of the first sentence of
16 section 215(b) (3) of such Act are amended to read as
17 follows:

18 “(A) in the case of a woman, the year in which
19 she died or, if it occurred earlier but after 1960, the
20 year in which she attained age 62,

21 “(B) in the case of a man who has died, the year
22 in which he died or, if it occurred earlier but after 1960,
23 the year in which he attained age 65, or

24 “(C) in the case of a man who has not died, the

1 year occurring after 1960 in which he attained (or
2 would attain) age 65.”

3 (3) Paragraphs (4) and (5) of section 215 (b) of
4 such Act are amended to read as follows:

5 “(4) The provisions of this subsection shall be appli-
6 cable only in the case of an individual—

7 “(A) who becomes entitled, after December 1965,
8 to benefits under section 202 (a) or section 223; or

9 “(B) who dies after December 1965 without being
10 entitled to benefits under section 202 (a) or section 223;
11 or

12 “(C) whose primary insurance amount is required
13 to be recomputed under subsection (f) (2), as amended
14 by the Social Security Amendments of 1965;

15 except that it shall not apply to any such individual for
16 purposes of monthly benefits for months before January
17 1966.

18 “(5) For the purposes of column III of the table
19 appearing in subsection (a) of this section, the provisions of
20 this subsection, as in effect prior to the enactment of the
21 Social Security Amendments of 1965, shall apply—

22 “(A) in the case of an individual to whom the
23 provisions of this subsection are not made applicable by
24 paragraph (4), but who, on or after the date of the
25 enactment of the Social Security Amendments of 1965

1 and prior to 1966, met the requirements of this para-
2 graph or paragraph (4), as in effect prior to such enact-
3 ment, and

4 “(B) with respect to monthly benefits for months
5 before January 1966, in the case of an individual to
6 whom the provisions of this subsection are made appli-
7 cable by paragraph (4).”

8 (b) (1) Subparagraph (A) of section 215(d) (1) of
9 such Act is amended by striking out “(2) (C) (i) and (3)
10 (A) (i)” and inserting in lieu thereof “(2) (C) and (3)”,
11 by striking out “December 31, 1936,” and inserting in lieu
12 thereof “1936”, and by striking out “December 31, 1950”
13 and inserting in lieu thereof “1950”.

14 (2) Section 215(d) (3) of such Act is amended by
15 striking out “1960” and inserting in lieu thereof “1965”
16 and by striking out “but without regard to whether such
17 individual has six quarters of coverage after 1950”.

18 (c) Section 215(e) of such Act is amended by insert-
19 ing “and” after the semicolon at the end of paragraph (1),
20 by striking out “; and” at the end of paragraph (2) and
21 inserting in lieu thereof a period, and by striking out para-
22 graph (3).

23 (d) (1) Paragraph (2) of section 215(f) of such Act
24 is amended to read as follows:

25 “(2) With respect to each year—

1 “(A) which begins after December 31, 1964, and

2 “(B) for any part of which an individual is en-
3 titled to old-age insurance benefits,

4 the Secretary shall, at such time or times and within such
5 period as he may by regulations prescribe, recompute the
6 primary insurance amount of such individual. Such recom-
7 putation shall be made—

8 “(C) as provided in subsection (a) (1) and (3)
9 if such year is either the year in which he became en-
10 titled to such old-age insurance benefits or the year
11 preceding such year, or

12 “(D) as provided in subsection (a) (1) in any
13 other case;

14 and in all cases such recomputation shall be made as though
15 the year with respect to which such recomputation is made
16 is the last year of the period specified in paragraph (2) (C)
17 of subsection (b). A recomputation under this paragraph
18 with respect to any year shall be effective—

19 “(E) in the case of an individual who did not die
20 in such year, for monthly benefits beginning with bene-
21 fits for January of the following year; or

22 “(F) in the case of an individual who died in such
23 year (including any individual whose increase in his
24 primary insurance amount is attributable to compensa-
25 tion which, upon his death, is treated as remuneration

1 for employment under section 205 (o)), for monthly
2 benefits beginning with benefits for the month in which
3 he died.”

4 (2) Effective January 2, 1966, paragraphs (3), (4),
5 and (7) of such section are repealed, and paragraphs (5)
6 and (6) of such section are redesignated as paragraphs (3)
7 and (4), respectively.

8 (e) (1) The first sentence of section 223 (a) (2) of
9 such Act is amended by inserting before the period at the
10 end thereof “and was entitled to an old-age insurance benefit
11 for each month for which (pursuant to subsection (b)) he
12 was entitled to a disability insurance benefit”.

13 (2) The last sentence of section 223 (a) (2) of such
14 Act is amended by striking out “first year” and inserting
15 in lieu thereof “year”; and by striking out the phrase “both
16 was fully insured and had” both times it appears in such
17 sentence.

18 (f) (1) The amendments made by subsection (c) shall
19 apply only to individuals who become entitled to old-age
20 insurance benefits under section 202 (a) of the Social
21 Security Act after 1965.

22 (2) Any individual who would, upon filing an applica-
23 tion prior to January 2, 1966, be entitled to a recomputation
24 of his benefit amount for purposes of title II of the Social
25 Security Act shall be deemed to have filed such application

1 on the earliest date on which such application could have
2 been filed, or on the day on which this Act is enacted, which-
3 ever is the later.

4 (3) In the case of an individual who died after 1960
5 and prior to 1966 and who was entitled to old-age insurance
6 benefits under section 202 (a) of the Social Security Act at
7 the time of his death, the provisions of sections 215 (f) (3)
8 (B) and 215 (f) (4) of such Act as in effect before the
9 enactment of this Act shall apply.

10 (4) In the case of a man who attains age 65 prior to
11 1966, or dies before such year, the provisions of section
12 215 (f) (7) of the Social Security Act as in effect before the
13 enactment of this Act shall apply.

14 (5) The amendments made by subsection (e) of this
15 section shall apply in the case of individuals who become
16 entitled to disability insurance benefits under section 223
17 of the Social Security Act after December 1965.

18 (6) Section 303 (g) (1) of the Social Security Amend-
19 ments of 1960 is amended—

20 (A) by striking out “notwithstanding the amend-
21 ments made by the preceding subsections of this sec-
22 tion,” in the first sentence and inserting in lieu thereof
23 “notwithstanding the amendments made by the preced-
24 ing subsections of this section, or the amendments made

1 by section 302 of the Social Security Amendments of
2 1965,"; and

3 (B) by striking out "Social Security Amendments
4 of 1960," in the second sentence and inserting in lieu
5 thereof "Social Security Amendments of 1960, or (if
6 such individual becomes entitled to old-age insurance
7 benefits after 1965, or dies after 1965 without becoming
8 so entitled) as amended by the Social Security Amend-
9 ments of 1965,".

10 DISABILITY INSURANCE BENEFITS

11 SEC. 303. (a) (1) Clause (A) of the first sentence of
12 section 216 (i) (1) of the Social Security Act is amended
13 by striking out "impairment which can be expected to result
14 in death or to be of long-continued and indefinite duration,"
15 and inserting in lieu thereof "impairment,".

16 (2) Section 223 (c) (2) of such Act is amended by
17 striking out "which can be expected to result in death or to
18 be of long-continued and indefinite duration".

19 (b) (1) Paragraph (2) of section 216 (i) of such Act
20 is amended to read as follows:

21 "(2) (A) The term 'period of disability' means a con-
22 tinuous period (beginning and ending as hereinafter pro-
23 vided in this subsection) during which an individual was
24 under a disability (as defined in paragraph (1)), but only

1 if such period is of not less than 6 full calendar months' dura-
2 tion or such individual was entitled to benefits under section
3 223 for one or more months in such period.

4 “(B) No period of disability shall begin as to any in-
5 dividual unless such individual files an application for a dis-
6 ability determination with respect to such period; and no
7 such period shall begin as to any individual after such in-
8 dividual attains the age of 65.

9 “(C) A period of disability shall begin—

10 “(i) on the day the disability began, but only if
11 the individual satisfies the requirements of paragraph
12 (3) on such day; or

13 “(ii) if such individual does not satisfy the require-
14 ments of paragraph (3) on such day, then on the first
15 day of the first quarter thereafter in which he satisfies
16 such requirements.

17 “(D) A period of disability shall end with the close of
18 the last day of the month preceding the month in which the
19 individual attains age 65 or, if earlier, the close of the last
20 day of—

21 “(i) the month following the month in which
22 the disability ceases if he has been under a disability
23 for a continuous period of less than 18 months, or

1 “(ii) the second month following the month in
2 which his disability ceases if he has been under a dis-
3 ability for a continuous period of at least 18 months.

4 “(E) No application for a disability determination
5 which is filed more than 3 months before the first day on
6 which a period of disability can begin (as determined under
7 this paragraph), or, in any case in which section 223 (d) (2)
8 applies, more than 6 months before the first month for which
9 such applicant becomes entitled to benefits under section
10 223, shall be accepted as an application for purposes of this
11 paragraph. Any application for a disability determination
12 which is filed within such 3 months’ period or 6 months’
13 period shall be deemed to have been filed on such first day
14 or in such first month, as the case may be.

15 “(F) No application for a disability determination
16 which is filed more than 12 months after the month pre-
17 scribed by subparagraph (D) as the month in which the
18 period of disability ends (determined without regard to
19 subparagraph (B) and this subparagraph) shall be accepted
20 as an application for purposes of this paragraph.”

21 (2) Section 216 (i) (3) of such Act is amended by
22 striking out “clauses (A) and (B) of paragraph (2)” and
23 inserting in lieu thereof “clauses (i) and (ii) of paragraph
24 (2) (C)”.

1 (3) Paragraph (1) of section 223 (a) of such Act is
2 amended to read as follows:

3 “(1) Every individual who—

4 “(A) is insured for disability insurance benefits (as
5 determined under subsection (c) (1)),

6 “(B) has not attained the age of 65, and

7 “(C) has filed application for disability insurance
8 benefits,

9 shall be entitled to a disability insurance benefit for each
10 month in his disability payment period (as defined in sub-
11 section (d)).”

12 (4) Section 223 (c) (3) (A) of such Act is amended
13 by striking out “which continues until such application is
14 filed”.

15 (c) Section 223 of such Act is amended by adding at
16 the end thereof the following new subsection:

17 “Disability Payment Period

18 “(d) (1) For purposes of this section, the term ‘dis-
19 ability payment period’ means, in the case of any applica-
20 tion, the period beginning with the last month of the
21 individual’s waiting period and ending with the month pre-
22 ceding whichever of the following months is the earliest:

23 “(A) the month in which he dies,

24 “(B) the month in which he attains age 65, or

1 “(C) either (i) the second month following the
2 month in which his disability ceases if he has been under
3 a disability for a continuous period of less than 18
4 calendar months, or (ii) the third month following the
5 month in which his disability ceases if he has been under
6 a disability for a continuous period of at least 18 calendar
7 months.

8 “(2) If—

9 “(A) an individual had a period of disability (as
10 defined in section 216(i)) which lasted at least 18
11 calendar months and which ceased within the 60-month
12 period preceding the first month of his waiting period,
13 and

14 “(B) such individual applies for disability insur-
15 ance benefits on the basis of a disability which at the
16 time of application can be expected to last a continuous
17 period of at least 12 months or to result in death,
18 then for purposes of this section, the term ‘disability pay-
19 ment period’ includes each month in the waiting period
20 with respect to which such application was filed.”

21 (d) (1) Section 222 (c) (5) of such Act is amended by
22 striking out “who becomes entitled to benefits under section
23 223 for any month as provided in clause (ii) of subsection
24 (a) (1) of this section,” and inserting in lieu thereof “to
25 whom section 223 (d) (2) is applicable,”.

1 (2) Section 223 (a) (2) (B) of such Act is amended
2 by striking out “clause (ii) of paragraph (1) of this sec-
3 tion” and inserting in lieu thereof “subsection (d) (2)”.

4 (3) (A) Section 223 (b) of such Act is amended—

5 (i) by striking out “clause (ii) of paragraph (1)
6 of subsection (a)” and inserting in lieu thereof “sub-
7 section (d) (2)”, and

8 (ii) by striking out the last sentence and inserting
9 in lieu thereof the following: “An individual who would
10 have been entitled to a disability insurance benefit for
11 any month had he filed application therefor before the
12 end of such month shall be entitled to such benefit for
13 such month if he files such application before the end
14 of the 12th month immediately succeeding such month.”

15 (B) The second sentence of section 202 (j) (1) of
16 such Act is amended by inserting “under this title” after
17 “Any benefit”.

18 (e) (1) The amendments made by subsection (a),
19 paragraphs (3) and (4) of subsection (b), and paragraph
20 (3) of subsection (d), and the provisions of subparagraphs
21 (B), (E), and (F) of section 216 (i) (2) of the Social
22 Security Act (as amended by subsection (b) (1) of this
23 section), shall be effective with respect to applications for
24 disability insurance benefits under section 223, and for dis-

1 ability determinations under section 216 (i), of the Social
2 Security Act filed—

3 (A) in or after the month in which this Act is
4 enacted, or

5 (B) before the month in which this Act is enacted,
6 if the applicant has not died before such month and if—

7 (i) notice of the final decision of the Secre-
8 tary of Health, Education, and Welfare has not been
9 given to the applicant before such month; or

10 (ii) the notice referred to in subparagraph
11 (i) has been so given before such month but a
12 civil action with respect to such final decision is
13 commenced under section 205 (g) of the Social
14 Security Act (whether before, in, or after such
15 month) and the decision in such civil action has
16 not become final before such month;

17 except that no monthly insurance benefits under title II of
18 the Social Security Act shall be payable or increased by
19 reason of the amendments made by subsections (a) and
20 (b) for months before the second month following the month
21 in which this Act is enacted.

22 (2) Section 223 (d) (1) of such Act (added by subsec-
23 tion (c) of this section) shall be applicable in the case of
24 applications for disability insurance benefits filed by indi-
25 viduals the last month of whose waiting period (as defined

1 in section 223 (c) (3) of such Act) occurs after the month
2 in which this Act is enacted; except that subparagraph (C)
3 of such section shall be applicable to individuals entitled
4 to disability insurance benefits whose disability (as defined
5 in section 223 (c) of the Social Security Act as amended
6 by this Act) ceases in or after the second month following
7 the month in which this Act is enacted.

8 (3) Section 223 (d) (2) of such Act (added by subsec-
9 tion (c) of this section), and the amendments made by sub-
10 section (d), shall be applicable in the case of applications for
11 disability insurance benefits under section 223, and for dis-
12 ability determinations under section 216 (i), of the Social
13 Security Act filed after the month in which this Act is
14 enacted.

15 (4) Section 216 (i) (2) (D) of such Act (as amended
16 by subsection (b) (1) of this section) shall apply with re-
17 spect to a disability (as defined in section 216 (i) of such
18 Act as amended by this Act) which ceases in or after the
19 second month following the month in which this Act is
20 enacted.

21 PAYMENT OF DISABILITY INSURANCE BENEFITS AFTER EN-
22 TITLEMENT TO OTHER MONTHLY INSURANCE BENEFITS

23 SEC. 304. (a) Section 202 (k) of the Social Security
24 Act is amended by adding at the end thereof the following
25 new paragraph:

1 “(4) Any individual who, under this section and sec-
2 tion 223, is entitled for any month to both an old-age insur-
3 ance benefit and a disability insurance benefit under this title
4 shall be entitled to only such disability insurance benefit for
5 such month.”

6 (b) The heading of section 202 (q) of such Act is
7 amended to read as follows:

8 “Reduction of Old-Age, Disability, Wife’s, Husband’s, or
9 Widow’s Insurance Benefit Amounts”

10 (c) Section 202 (q) of such Act is further amended by
11 renumbering paragraphs (2), (3), (4), (5), (6), and
12 (7) as paragraphs (3), (4), (5), (6), (7), and (8),
13 respectively, by renumbering the cross references in such
14 section accordingly, and by inserting after paragraph (1)
15 the following new paragraph:

16 “(2) If an individual is entitled to a disability insur-
17 ance benefit for a month after a month for which such
18 individual was entitled to an old-age insurance benefit, such
19 disability insurance benefit for each month shall be reduced
20 by the amount such old-age insurance benefit would be
21 reduced under paragraphs (1) and (4) for such month had
22 such individual attained age 65 in the first month for which
23 he most recently became entitled to a disability insurance
24 benefit.”

25 (d) Subparagraph (B) of paragraph (3) (as redesignig-

1 nated by subsection (c) of this section) of section 202 (q)
2 of such Act is amended by—

3 (1) striking out “benefit,” the first time it appears
4 and inserting in lieu thereof “benefit and is not entitled
5 to a disability insurance benefit,”;

6 (2) striking out in clause (i) thereof “(1),” and
7 inserting in lieu thereof “(1) for such month,”; and

8 (3) striking out in clause (ii) thereof “(1)” and
9 inserting in lieu thereof “(1) for such month”.

10 (e) Subparagraph (C) of paragraph (3) (as redesign-
11 nated by subsection (c) of this section) of section 202 (q)
12 of such Act is amended to read as follows:

13 “(C) For any month for which such individual is en-
14 titled to a disability insurance benefit, such individual’s wife’s,
15 husband’s, or widow’s insurance benefit shall be reduced by
16 the sum of—

17 “(i) the amount by which such disability insurance
18 benefit is reduced under paragraph (2) for such month
19 (if such paragraph applied to such benefit), and

20 “(ii) the amount by which such wife’s, husband’s,
21 or widow’s insurance benefit would be reduced under
22 paragraph (1) for such month if it were equal to the
23 excess of such wife’s, husband’s, or widow’s insurance
24 benefit (before reduction under this subsection) over

1 such disability insurance benefit (before reduction under
2 this subsection).”

3 (f) Paragraph (3) (as redesignated by subsection (c)
4 of this section) of section 202 (q) is further amended by
5 adding after paragraph (E) (added by section 307 (b) (4)
6 of this Act) the following new paragraphs:

7 “(F) If the first month for which an individual is
8 entitled to a disability insurance benefit (when such first
9 month occurs with or after the month in which such indi-
10 vidual attains the age of 62) is a month for which such
11 individual is also (or would, but for subsection (e) (1), be)
12 entitled to a widow’s insurance benefit to which such indi-
13 vidual was first entitled for a month before she attained
14 retirement age, then such disability insurance benefit for each
15 month shall be reduced by whichever of the following is
16 larger:

17 “(i) the amount by which (but for this subpara-
18 graph) such disability insurance benefit would have been
19 reduced under paragraph (2), or

20 “(ii) the amount equal to the sum of the amount by
21 which such widow’s insurance benefit was reduced for
22 the month in which such individual attained retirement
23 age and the amount by which such disability insurance
24 benefit would be reduced under paragraph (2) if it
25 were equal to the excess of such disability insurance
26 benefit (before reduction under this subsection) over

1 such widow's insurance benefit (before reduction under
2 this subsection).

3 “(G) If the first month for which an individual is en-
4 titled to a disability insurance benefit (when such first
5 month occurs before the month in which such individual
6 attains the age of 62) is a month for which such individual
7 is also (or would, but for subsection (e) (1), be) entitled
8 to a widow's insurance benefit, then such disability insurance
9 benefit for each month shall be reduced by the amount such
10 widow's insurance benefit would be reduced under para-
11 graphs (1) and (4) for such month had such individual
12 attained age 62 in the first month for which he most recently
13 became entitled to a disability insurance benefit.”

14 (g) Paragraph (4) (as redesignated by subsection (c)
15 of this section) of section 202 (q) of such Act is amended
16 by striking out in subparagraph (A) thereof “under” and
17 inserting in lieu thereof: “under paragraph (1) or (3) of”.

18 (h) Paragraph (7) (as redesignated by subsection (c)
19 of this section and as amended by section 307 (b) (7) of
20 this Act) of section 202 (q) of such Act is amended by
21 adding after subparagraph (E) the following new sub-
22 paragraph:

23 “(F) in the case of old-age insurance benefits, any
24 month for which such individual was entitled to a dis-
25 ability insurance benefit.”

1 (i) Paragraph (8) (as redesignated by subsection (c)
2 of this section) of section 202 (q) of such Act is amended by
3 striking out “(1)” and inserting in lieu thereof “(1), (2),”.

4 (j) Section 202 (r) (2) of such Act is amended by
5 inserting after “eligible” the following: “(but for section
6 202 (k) (4))”.

7 (k) So much of section 215 (a) (4) of such Act as
8 follows clause (B) is amended by striking out “such dis-
9 ability insurance benefit” and inserting in lieu thereof “the
10 primary insurance amount upon which such disability insur-
11 ance benefit is based”.

12 (l) Section 216 (i) (2) of such Act is amended by
13 striking out “(subject to section 223 (a) (3))”.

14 (m) Section 223 (a) (2) of such Act is amended by
15 striking out the word “Such” and inserting in lieu thereof
16 “Except as provided in section 202 (q) , such”.

17 (n) Section 223 (a) (3) of such Act is repealed.

18 (o) The amendments made by this section shall apply
19 with respect to monthly insurance benefits under title II of
20 the Social Security Act for and after the second month
21 following the month in which this Act is enacted, but only
22 on the basis of applications filed in or after the month in
23 which this Act is enacted.

1 DISABILITY INSURANCE TRUST FUND

2 SEC. 305. (a) Section 201 (b) (1) of the Social Secu-
3 rity Act is amended by inserting "and before January 1,
4 1966," after "December 31, 1956," and by inserting after
5 "1954," the following: "and $\frac{3}{4}$ of 1 per centum of the wages
6 (as so defined) paid after December 31, 1965, and so
7 reported,".

8 (b) Section 201 (b) (2) of such Act is amended by
9 inserting after "December 31, 1956," the following: "and
10 before January 1, 1966, and $\frac{9}{16}$ of 1 per centum of the
11 amount of self-employment income (as so defined) so re-
12 ported for any taxable year beginning after December 31,
13 1965,".

14 PAYMENT OF CHILD'S INSURANCE BENEFITS AFTER AT-
15 TAINMENT OF AGE 18 IN CASE OF CHILD ATTENDING
16 SCHOOL

17 SEC. 306. (a) Section 202 (d) (1) (B) of the Social
18 Security Act is amended to read as follows:

19 "(B) at the time such application was filed was
20 unmarried and (i) either had not attained the age of
21 18 or was a full-time student and had not attained
22 the age of 22, or (ii) is under a disability (as defined
23 in section 223 (c)) which began before he attained
24 the age of 18 and which has lasted or can be expected

1 to last a continuous period of at least 6 calendar months
2 or to result in death, and”.

3 (b) (1) So much of the first sentence of section 202
4 (d) (1) of such Act as follows subparagraph (C) is
5 amended to read as follows:

6 “shall be entitled to a child’s insurance benefit for each
7 month, beginning with the first month after August 1950
8 in which such child becomes so entitled to such insurance
9 benefits and ending with the month preceding whichever
10 of the following first occurs—

11 “(D) the month in which such child dies, marries,
12 or is adopted (except for adoption by a stepparent,
13 grandparent, aunt, or uncle subsequent to the death of
14 such fully or currently insured individual),

15 “(E) in the case of a child who is not under a
16 disability (as so defined) at the time he attains the
17 age of 18 and who during no part of the month in
18 which he attains such age is a full-time student, the
19 month in which such child attains the age of 18,

20 “(F) in the case of a child who is a full-time stu-
21 dent during the month in which he attains the age of 18,
22 the first month (beginning after he attains such age)
23 during no part of which he is a full-time student or the
24 month in which he attains the age of 22, whichever

1 occurs earlier, but only if in the third month preceding
2 such earlier month he was not under a disability (as
3 so defined) which began before he attained the age of
4 18,

5 “(G) in the case of a child who first becomes en-
6 titled to benefits under this subsection for the month in
7 which he attains the age of 18 or a subsequent month
8 and who in the month for which he becomes so entitled
9 is not under a disability (as so defined) which began
10 before he attained the age of 18, the first month
11 (after he becomes so entitled) during no part of which
12 he is a full-time student or the month in which he at-
13 tains the age of 22, whichever occurs earlier,

14 “(H) in the case of a child who after he attains
15 the age of 18 ceases to be under a disability (as so
16 defined) which began before he attained the age of 18,
17 and who either—

18 “(i) attains the age of 22 before the close of
19 the third month following the month in which he
20 ceases to be under such disability, or

21 “(ii) was a full-time student during no part
22 of the third month following the month in which he
23 ceases to be under such disability if he has been
24 under a disability for a continuous period of at least

1 18 months (or the second month following the
2 month in which he ceases to be under such disability
3 if he has been under a disability for a continuous
4 period of less than 18 months),

5 the third month (or the second month) following the
6 month in which he ceases to be under such disability, or

7 “(I) in the case of a child who after he attains
8 the age of 18 ceases to be under a disability (as so
9 defined) which began before he attained the age of 18,
10 but who has not attained the age of 22 before the close
11 of the third month following the month in which he
12 ceases to be under such disability if he has been under a
13 disability for a continuous period of at least 18 months
14 (or before the close of the second month following the
15 month in which he ceases to be under such disability
16 if he has been under a disability for a continuous period
17 of less than 18 months) and is a full-time student
18 in such third month (or such second month), the earlier
19 of (i) the first month (after such third month or such
20 second month) during no part of which he is a full-time
21 student, or (ii) the month in which he attains the age
22 of 22.”

23 (2) The second sentence of section 202 (d) (1) of such
24 Act is repealed.

25 (3) Section 202 (d) of such Act is further amended

1 by adding at the end thereof the following new paragraphs:

2 “(7) A child whose entitlement to child’s insurance
3 benefits on the basis of the wages and self-employment in-
4 come of an insured individual terminated with the month
5 preceding the month in which such child attained the age
6 of 18, or with a subsequent month, may again become en-
7 titled to such benefits (provided no event specified in para-
8 graph (1) (D) has occurred) beginning with the first
9 month thereafter in which he is a full-time student and has
10 not attained the age of 22 if he has filed application for such
11 reentitlement. Such reentitlement shall end with the month
12 preceding whichever of the following first occurs: The first
13 month during no part of which he is a full-time student, the
14 month in which he attains the age of 22, or the first month
15 in which an event specified in paragraph (1) (D) occurs.

16 “(8) For the purposes of this subsection—

17 “(A) A ‘full-time student’ is an individual who
18 is in full-time attendance as a student at an educational
19 institution, as determined by the Secretary (in accord-
20 ance with regulations prescribed by him) in the light
21 of the standards and practices of the institutions in-
22 volved, except that no individual shall be considered a
23 ‘full-time student’ if he is paid by his employer while

1 attending an educational institution at the request, or
2 pursuant to a requirement, of his employer.

3 “(B) Except to the extent provided in such regula-
4 tions, an individual shall be deemed to be a full-time
5 student during any period of nonattendance at an educa-
6 tional institution at which he has been in full-time attend-
7 ance if (i) such period is 4 calendar months or less, and
8 (ii) he shows to the satisfaction of the Secretary that he
9 intends to continue to be in full-time attendance at an
10 educational institution immediately following such
11 period. An individual who does not meet the require-
12 ment of clause (ii) with respect to such period of non-
13 attendance shall be deemed to have met such require-
14 ment (as of the beginning of such period) if he is in
15 full-time attendance at an educational institution im-
16 mediately following such period.

17 “(C) An ‘educational institution’ is (i) a school or
18 college or university operated or directly supported by
19 the United States, or by any State or local government
20 or political subdivision thereof, or (ii) a school or college
21 or university which has been approved by a State or
22 accredited by a State-recognized or nationally-recognized
23 accrediting agency or body, or (iii) a nonaccredited
24 school or college or university whose credits are ac-
25 cepted, on transfer, by not less than three institutions

1 which are so accredited, for credit on the same basis as if
2 transferred from an institution so accredited.”

3 (c) (1) Section 202 of such Act is amended by insert-
4 ing immediately after subsection (r) the following new
5 subsection:

6 “Child Aged 18 or Over Attending School

7 “(s) (1) For the purposes of subsections (b) (1), (g)
8 (1), (q) (5), and (q) (7) of this section and paragraphs
9 (2), (3), and (4) of section 203 (c), a child who is entitled
10 to child’s insurance benefits under subsection (d) for any
11 month, and who has attained the age of 18 but is not in such
12 month under a disability (as defined in section 223 (c))
13 which began before he attained such age, shall be deemed
14 not entitled to such benefits for such month, unless he was
15 under such a disability in the third month before such month
16 and had been under such disability for a continuous period
17 of at least 18 months (or in the second month if he had been
18 under such disability for a continuous period of less than 18
19 months) .

20 “(2) Subsection (f) (4), and so much of subsections
21 (b) (4), (d) (6), (e) (4), (g) (4), and (h) (4) of this sec-
22 tion as precedes the semicolon, shall not apply in the case of
23 any child unless such child, at the time of the marriage re-
24 ferred to therein, was under a disability (as defined in section
25 223 (c)) which began before such child attained the age of 18

1 or had been under such a disability in the third month before
 2 the month in which such marriage occurred and had been
 3 under such disability for a continuous period of at least 18
 4 months (or in the second month if he had been under such
 5 disability for a continuous period of less than 18 months) .

6 “(3) Subsections (c) (2) (B) and (f) (2) (B) of this
 7 section, so much of subsections (b) (4), (d) (6), (e) (4),
 8 (g) (4), and (h) (4) of this section as follows the semi-
 9 colon, the last sentence of subsection (c) of section 203,
 10 subsection (f) (1) (C) of section 203, and subsections
 11 (b) (3) (B), (c) (6) (B), (f) (3) (B), and (g) (6) (B)
 12 of section 216 shall not apply in the case of any child with
 13 respect to any month referred to therein unless in such month
 14 or the third month prior thereto such child was under a dis-
 15 ability (as defined in section 223 (c)) which began before
 16 such child attained the age of 18 and had been under such
 17 disability for a continuous period of at least 18 months (or in
 18 the second month if he had been under such disability for a
 19 continuous period of less than 18 months) .”

20 (2) So much of subsection (c) (2) of such section 202
 21 as precedes subparagraph (A) is amended by inserting
 22 “(subject to subsection (s))” after “shall”.

23 (3) So much of subsection (d) (6) of such section 202
 24 as follows subparagraph (B) is amended by inserting “but

1 subject to subsection (s)” after “notwithstanding the pro-
2 visions of paragraph (1)”.

3 (4) So much of subsection (e) (4) of such section 202
4 as follows subparagraph (B) is amended by inserting “but
5 subject to subsection (s)” after “notwithstanding the pro-
6 visions of paragraph (1)”.

7 (5) So much of subsection (f) (2) of such section 202
8 as precedes subparagraph (A) is amended by inserting
9 “(subject to subsection (s))” after “shall”.

10 (6) So much of subsection (f) (4) of such section 202
11 as follows subparagraph (B) is amended by inserting “but
12 subject to subsection (s)” after “notwithstanding the pro-
13 visions of paragraph (1)”.

14 (7) So much of the first sentence of subsection (g) (1)
15 of such section 202 as follows subparagraph (F) is amended
16 by inserting “(subject to subsection (s))” after “shall”.

17 (8) So much of subsection (g) (4) of such section 202
18 as follows subparagraph (B) is amended by inserting “but
19 subject to subsection (s)” after “notwithstanding the provi-
20 sions of paragraph (1)”.

21 (9) So much of subsection (h) (4) of such section 202
22 as follows subparagraph (B) is amended by inserting “but
23 subject to subsection (s)” after “notwithstanding the pro-
24 visions of paragraph (1)”.

1 (10) The next to last sentence of subsection (c)
2 of section 203 of such Act is amended by striking out “for
3 any month in which” and inserting in lieu thereof “for any
4 month in which paragraph (1) of section 202 (s) applies
5 or”.

6 (11) The last sentence of subsection (c) of such section
7 203 is amended by striking out “No” and inserting in lieu
8 thereof “Subject to paragraph (3) of such section 202 (s),
9 no”.

10 (12) The last sentence of subsection (f) (1) of such
11 section 203 is amended by inserting “but subject to section
12 202 (s)” after “Notwithstanding the preceding provisions
13 of this paragraph”.

14 (13) Subsections (b), (c), (f), and (g) of section 216
15 of such Act are each amended by inserting before the period
16 at the end thereof “(subject, however, to section 202 (s))”.

17 (14) Section 222 (b) of such Act is amended by adding
18 at the end thereof the following new paragraph:

19 “(4) The provisions of paragraph (1) shall not apply
20 to any child entitled to benefits under section 202 (d), if he
21 has attained the age of 18 but has not attained the age of 22,
22 for any month during which he is a full-time student (as
23 defined and determined under section 202 (d)).”

24 (15) Section 225 of such Act is amended by adding at
25 the end thereof the following new sentence: “The first sen-
26 tence of this section shall not apply to any child entitled to

1 benefits under section 202 (d) , if he has attained the age of
2 18 but has not attained the age of 22, for any month during
3 which he is a full-time student (as defined and determined
4 under section 202 (d)).”

5 (d) The amendments made by this section shall apply
6 with respect to monthly insurance benefits under section 202
7 of the Social Security Act for months after December 1964;
8 except that—

9 (1) in the case of an individual who was not en-
10 titled to a child’s insurance benefit under subsection
11 (d) of such section for the month in which this Act is
12 enacted, such amendments shall apply only on the basis
13 of an application filed in or after the month in which
14 this Act is enacted,

15 (2) section 202 (d) (1) (H) (ii) of such Act (as
16 amended by this section) shall apply only for months
17 after the month in which this Act is enacted, and

18 (3) no monthly insurance benefit shall be payable
19 for any month before the second month following the
20 month in which this Act is enacted by reason of section
21 202 (d) (1) (B) (ii) of the Social Security Act as
22 amended by this section.

23 REDUCED BENEFITS FOR WIDOWS AT AGE 60

24 SEC. 307. (a) (1) Paragraph (1) (B) of section 202
25 (e) of the Social Security Act (as amended by section

1 308 (b) of this Act) is amended by striking out "age 62"
2 and inserting in lieu thereof "age 60".

3 (2) Paragraph (2) of such section (as so amended)
4 is amended by striking out "Such" and inserting in lieu
5 thereof "Except as provided in subsection (q), such".

6 (b) (1) Paragraph (1) of section 202 (q) of such
7 Act is amended to read as follows:

8 " (1) If the first month for which an individual is
9 entitled to an old-age, wife's, husband's, or widow's insurance
10 benefit is a month before the month in which such indi-
11 vidual attains retirement age, the amount of such benefit
12 for each month shall, subject to the succeeding paragraphs
13 of this subsection, be reduced by—

14 " (A) $\frac{5}{9}$ of 1 percent of such amount if such bene-
15 fit is an old-age or widow's insurance benefit, or $\frac{25}{36}$
16 of 1 percent of such amount if such benefit is a wife's or
17 husband's insurance benefit, multiplied by

18 " (B) (i) the number of months in the reduction
19 period for such benefit (determined under paragraph
20 (6)), if such benefit is for a month before the month
21 in which such individual attains retirement age, or

22 " (ii) the number of months in the adjusted reduc-
23 tion period for such benefit (determined under para-
24 graph (7)), if such benefit is for the month in which

1 such individual attains retirement age or for any month
2 thereafter.”

3 (2) Paragraph (3) (A) (as renumbered by section
4 304 (c) of this Act) of such section is amended—

5 (A) by striking out “wife’s or husband’s insurance
6 benefit” each place it appears and inserting in lieu
7 thereof “wife’s, husband’s, or widow’s insurance bene-
8 fit”; and

9 (B) by striking out “age 62” and inserting in lieu
10 thereof “age 62 (in the case of a wife’s or husband’s
11 insurance benefit) or age 60 (in the case of a widow’s
12 insurance benefit) ”.

13 (3) Paragraph (3) (D) (as so renumbered) of such
14 section is amended by striking out “wife’s or husband’s” and
15 inserting in lieu thereof “wife’s, husband’s, or widow’s”.

16 (4) Paragraph (3) (as so renumbered) of such section
17 is amended by adding at the end thereof the following new
18 subparagraph:

19 “(E) If the first month for which an individual is
20 entitled to an old-age insurance benefit (whether such first
21 month occurs before, with, or after the month in which such
22 individual attains the age of 65) is a month for which such
23 individual is also (or would, but for subsection (e) (1), be)
24 entitled to a widow’s insurance benefit to which such indi-

1 vidual was first entitled for a month before she attained
 2 retirement age, then such old-age insurance benefit shall be
 3 reduced by whichever of the following is the larger:

4 “(i) the amount by which (but for this subpara-
 5 graph) such old-age insurance benefit would have been
 6 reduced under paragraph (1), or

7 “(ii) the amount equal to the sum of the amount by
 8 which such widow’s insurance benefit was reduced for
 9 the month in which such individual attained retirement
 10 age and the amount by which such old-age insurance
 11 benefit would be reduced under paragraph (1) if it were
 12 equal to the excess of such old-age insurance benefit
 13 (before reduction under this subsection) over such
 14 widow’s insurance benefit (before reduction under this
 15 subsection).”

16 (5) Paragraph (5) (as so renumbered) of such sec-
 17 tion is amended by adding at the end thereof the following
 18 new subparagraph:

19 “(D) No widow’s insurance benefit for a month in which
 20 she has in her care a child of her deceased husband (or
 21 deceased former husband) entitled to child’s insurance bene-
 22 fits shall be reduced under this subsection below the amount
 23 to which she would have been entitled had she been entitled
 24 for such month to mother’s insurance benefits on the basis of
 25 her deceased husband’s (or deceased former husband’s)
 26 wages and self-employment income.”

1 (6) Paragraph (6) (as so renumbered) of such sec-
2 tion is amended—

3 (A) by striking out “wife’s, or husband’s” and in-
4 serting in lieu thereof “wife’s, husband’s, or widow’s”;

5 (B) by striking out “or husband’s” in subparagraph
6 (A) (i) and inserting in lieu thereof “, husband’s, or
7 widow’s”; and

8 (C) by striking out “age 65” in subparagraph (B)
9 and inserting in lieu thereof “retirement age”.

10 (7) Paragraph (7) (as so renumbered) of such sec-
11 tion is amended—

12 (A) by striking out “wife’s, or husband’s” and in-
13 serting in lieu thereof “wife’s, husband’s, or widow’s”;
14 and

15 (B) by striking out “and” at the end of subpara-
16 graph (B), by striking out the period at the end of
17 subparagraph (C) and inserting in lieu thereof a comma,
18 and by adding at the end thereof the following new sub-
19 paragraphs:

20 “(D) in the case of widow’s insurance benefits,
21 any month in which the reduction in the amount of
22 such benefit was determined under paragraph (5) (D),

23 “(E) in the case of widow’s insurance benefits, any
24 month before the month in which she attained retire-
25 ment age for which she was not entitled to such benefit

1 because of the occurrence of an event that terminated
2 her entitlement to such benefits, and”.

3 (8) Section 202 (q) of such Act (as amended by
4 section 304 (c) of this Act) is further amended by adding
5 at the end thereof the following new paragraph:

6 “(9) For purposes of this subsection, the term ‘retire-
7 ment age’ means age 65 with respect to an old-age, wife’s,
8 or husband’s insurance benefit and age 62 with respect to
9 a widow’s insurance benefit.”

10 (c) The amendments made by this section shall apply
11 with respect to monthly insurance benefits under section 202
12 of the Social Security Act for and after the second month
13 following the month in which this Act is enacted, but only
14 on the basis of applications filed in or after the month in
15 which this Act is enacted.

16 WIFE’S AND WIDOW’S BENEFITS FOR DIVORCED WOMEN

17 SEC. 308. (a) Section 202 (b) of the Social Security
18 Act is amended to read as follows:

19 “Wife’s Insurance Benefits

20 “(b) (1) The wife (as defined in section 216 (b)) and
21 every divorced wife (as defined in section 216 (d)) of an
22 individual entitled to old-age or disability insurance benefits,
23 if such wife or such divorced wife—

24 “(A) has filed application for wife’s insurance
25 benefits,

1 “(B) has attained age 62 or (in the case of a wife)
2 has in her care (individually or jointly with such indi-
3 vidual) at the time of filing such application a child en-
4 titled to a child’s insurance benefit on the basis of the
5 wages and self-employment income of such individual,

6 “(C) in the case of a divorced wife, has not re-
7 married,

8 “(D) in the case of a divorced wife, was receiving
9 at least one-half of her support, as determined in accord-
10 ance with regulations prescribed by the Secretary, from
11 such individual, or was receiving substantial contribu-
12 tions from such individual (pursuant to a written agree-
13 ment) or there was in effect a court order for substantial
14 contributions to her support from such individual—

15 “(i) if he had a period of disability which did
16 not end before the month in which he became en-
17 titled to old-age or disability insurance benefits, at
18 the beginning of such period or at the time he be-
19 came entitled to such benefits, or

20 “(ii) if he did not have such a period of dis-
21 ability, at the time he became entitled to old-age
22 insurance benefits, and

23 “(E) is not entitled to old-age or disability insur-
24 ance benefits, or is entitled to old-age or disability
25 insurance benefits based on a primary insurance amount

1 which is less than one-half of the primary insurance
2 amount of such individual,
3 shall (subject to subsection (s)) be entitled to a wife's
4 insurance benefit for each month, beginning with the first
5 month in which she becomes so entitled to such insurance
6 benefits and ending with the month preceding the first month
7 in which any of the following occurs—

8 “(F) she dies,

9 “(G) such individual dies,

10 “(H) in the case of a wife, they are divorced and
11 either (i) she has not attained age 62, or (ii) she has
12 attained age 62 but has not been married to such in-
13 dividual for a period of 20 years immediately before the
14 date the divorce became effective,

15 “(I) in the case of a divorced wife, she marries a
16 person other than such individual,

17 “(J) in the case of a wife who has not attained age
18 62, no child of such individual is entitled to a child's
19 insurance benefit,

20 “(K) she becomes entitled to an old-age or dis-
21 ability insurance benefit based on a primary insurance
22 amount which is equal to or exceeds one-half of the pri-
23 mary insurance amount of such individual, or

24 “(L) such individual is not entitled to disability
25 insurance benefits and is not entitled to old-age insurance
26 benefits.

1 “(2) Except as provided in subsection (q), such wife’s
2 insurance benefit for each month shall be equal to one-half
3 of the primary insurance amount of her husband (or, in the
4 case of a divorced wife, her former husband) for such month.

5 “(3) In the case of any divorced wife of an individual—

6 “(A) who marries another individual, and

7 “(B) whose marriage to the individual referred to
8 in subparagraph (A) is terminated by divorce which
9 occurs within 20 years after such marriage,
10 the marriage to the individual referred to in subparagraph
11 (A) shall, for the purposes of paragraph (1), be deemed not
12 to have occurred. No benefits shall be payable under this sub-
13 section by reason of the preceding sentence for any month
14 before whichever of the following is the latest: (i) the
15 month after the month in which the divorce referred to in
16 subparagraph (B) of the preceding sentence occurs, (ii) the
17 twelfth month before the month in which such divorced wife
18 files application for purposes of this paragraph, or (iii) the
19 second month after the month in which this paragraph is
20 enacted.

21 “(4) In the case of any divorced wife who marries—

22 “(A) an individual entitled to benefits under sub-
23 section (f) or (h) of this section, or

24 “(B) an individual who has attained the age of
25 18 and is entitled to benefits under subsection (d),
26 such divorced wife’s entitlement to benefits under this sub-

1 section shall, notwithstanding the provisions of paragraph
 2 (1) (but subject to subsection (s)), not be terminated by
 3 reason of such marriage; except that, in the case of such a
 4 marriage to an individual entitled to benefits under sub-
 5 section (d), the preceding provisions of this paragraph shall
 6 not apply with respect to benefits for months after the last
 7 month for which such individual is entitled to such benefits
 8 under subsection (d) unless he ceases to be so entitled by
 9 reason of his death.”

10 (b) (1) Paragraphs (1) and (2) of section 202 (e) of
 11 such Act are amended to read as follows:

12 “(1) The widow (as defined in section 216 (c)) and
 13 every surviving divorced wife (as defined in section 216
 14 (d)) of an individual who died a fully insured individual, if
 15 such widow or such surviving divorced wife—

16 “(A) has not remarried,

17 “(B) has attained age 62,

18 “(C) (i) has filed application for widow’s insur-
 19 ance benefits, or was entitled, after attainment of age
 20 62, to wife’s insurance benefits, on the basis of the
 21 wages and self-employment income of such individual,
 22 for the month preceding the month in which he died, or

23 “(ii) was entitled, on the basis of such wages and
 24 self-employment income, to mother’s insurance benefits

1 for the month preceding the month in which she attained
2 age 62,

3 “(D) in the case of a surviving divorced wife, was
4 receiving at least one-half of her support, as determined
5 in accordance with regulations prescribed by the Secre-
6 tary, from such individual, or was receiving substantial
7 contributions from such individual (pursuant to a writ-
8 ten agreement) or there was in effect a court order for
9 substantial contributions to her support from such in-
10 dividual—

11 “(i) at the time of his death (or, if such indi-
12 vidual had a period of disability which did not end
13 prior to the month in which he died, at the time such
14 period began or at the time of his death), or

15 “(ii) at the time he became entitled to old-age
16 insurance benefits or disability insurance benefits
17 (or, if such individual had a period of disability
18 which did not end before the month in which he
19 became entitled to such benefits, at the time such
20 period began or at the time he became entitled to
21 such benefits), and

22 “(E) is not entitled to old-age insurance benefits or
23 is entitled to old-age insurance benefits each of which

1 is less than $82\frac{1}{2}$ percent of the primary insurance amount
2 of such deceased individual,
3 shall be entitled to a widow's insurance benefit for each
4 month, beginning with the first month in which she be-
5 comes so entitled to such insurance benefits and ending with
6 the month preceding the first month in which any of the
7 following occurs: she remarries, dies, or becomes entitled
8 to an old-age insurance benefit equal to or exceeding $82\frac{1}{2}$
9 percent of the primary insurance amount of such deceased
10 individual.

11 “(2) Such widow's insurance benefit for each month
12 shall be equal to $82\frac{1}{2}$ percent of the primary insurance
13 amount of such deceased individual.”

14 (2) Paragraphs (3) and (4) of section 202 (e) of
15 such Act are amended by striking out “widow” each place
16 it appears and inserting in lieu thereof “widow or surviving
17 divorced wife”.

18 (3) Paragraph (4) of section 202 (e) of such Act is
19 amended by striking out “widow's” and inserting in lieu
20 thereof “widow's or surviving divorced wife's”.

21 (4) Section 202 (e) of such Act is further amended by
22 adding at the end thereof the following new paragraph:

23 “(5) In the case of any widow or surviving divorced
24 wife of an individual—

25 “(A) who marries another individual, and

1 “(B) whose marriage to the individual referred to
2 in subparagraph (A) is terminated by divorce which
3 occurs within 20 years after such marriage,
4 the marriage to the individual referred to in subparagraph (A)
5 shall, for the purposes of paragraph (1), be deemed not to
6 have occurred. No benefits shall be payable under this sub-
7 section by reason of the preceding sentence for any month
8 before whichever of the following is the latest: (i) the
9 month after the month in which the divorce referred to in
10 subparagraph (B) of the preceding sentence occurs, (ii)
11 the twelfth month before the month in which such widow or
12 surviving divorced wife files application for purposes of this
13 paragraph, or (iii) the second month after the month in
14 which this paragraph is enacted.”

15 (c) Section 216 (d) of such Act is amended to read as
16 follows:

17 “Divorced Wives; Divorce

18 “(d) (1) The term ‘divorced wife’ means a woman
19 divorced from an individual, but only if she had been married
20 to such individual for a period of 20 years immediately before
21 the date the divorce became effective.

22 “(2) The term ‘surviving divorced wife’ means a
23 woman divorced from an individual who has died, but only
24 if she had been married to the individual for a period of 20

1 years immediately before the date the divorce became
2 effective.

3 “(3) The term ‘surviving divorced mother’ means a
4 woman divorced from an individual who has died, but only if
5 (A) she is the mother of his son or daughter, (B) she legally
6 adopted his son or daughter while she was married to him and
7 while such son or daughter was under the age of 18, (C) he
8 legally adopted her son or daughter while she was married to
9 him and while such son or daughter was under the age of 18,
10 or (D) she was married to him at the time both of them
11 legally adopted a child under the age of 18.

12 “(4) The terms ‘divorce’ and ‘divorced’ refer to a
13 divorce a vinculo matrimonii.”

14 (d) (1) Section 202 (c) (1) of such Act is amended
15 by striking out “divorced a vinculo matrimonii,” and insert-
16 ing in lieu thereof “divorced,”.

17 (2) (A) Subsections (d) (6) (A), (f) (4) (A), and
18 (h) (4) (A) of section 202 of such Act are each amended
19 by inserting “(b),” before “(e),”.

20 (B) Subsections (b) and (c) of section 216 of such
21 Act are each amended by striking out “(e) or” and inserting
22 in lieu thereof “(b), (e), or”.

23 (3) Subparagraph (F) of section 202 (g) (1) of such
24 Act is amended to read as follows:

25 “(F) in the case of a surviving divorced mother—

1 “(i) at the time of such individual’s death (or,
2 if such individual had a period of disability which
3 did not end before the month in which he died, at
4 the time such period began or at the time of such
5 death) —

6 “(I) she was receiving at least one-half of
7 her support, as determined in accordance with
8 regulations prescribed by the Secretary, from
9 such individual, or

10 “(II) she was receiving substantial con-
11 tributions from such individual (pursuant to a
12 written agreement), or

13 “(III) there was a court order for sub-
14 stantial contributions to her support from such
15 individual,

16 “(ii) the child referred to in subparagraph (E)
17 is her son, daughter, or legally adopted child, and

18 “(iii) the benefits referred to in such subpara-
19 graph are payable on the basis of such individual’s
20 wages and self-employment income,”.

21 (4) Section 202 (g) of such Act is amended by adding
22 the following new paragraph:

23 “(5) In the case of any widow or surviving divorced
24 mother—

25 “(A) who marries another individual, and

1 “(B) whose marriage to the individual referred to
2 in subparagraph (A) is terminated by divorce which
3 occurs within 20 years after such marriage,
4 the marriage to the individual referred to in subparagraph
5 (A) shall, for the purposes of paragraph (1), be deemed not
6 to have occurred. No benefits shall be payable under this
7 subsection by reason of the preceding sentence for any month
8 prior to whichever of the following is the latest: (i) the
9 month after the month in which the divorce referred to in
10 subparagraph (B) of the preceding sentence occurs, (ii) the
11 twelfth month before the month in which such widow or sur-
12 viving divorced mother files application for purposes of this
13 paragraph, or (iii) the second month after the month in
14 which this paragraph is enacted.”

15 (5) Section 202 (g) of such Act is further amended
16 by striking out “former wife divorced” each place it appears
17 and inserting in lieu thereof “surviving divorced mother”.

18 (6) Section 203 (a) of such Act (as amended by sec-
19 tion 301 (c) of this Act) is amended by striking out the
20 period at the end of the first sentence and inserting in lieu
21 thereof “, or” and by adding the following new paragraph:

22 “(3) when any of such individuals is entitled to
23 monthly benefits as a divorced wife under section
24 202 (b) or as a surviving divorced wife under section
25 202 (e) for any month, the benefit to which she is en-

1 titled on the basis of the wages and self-employment in-
2 come of such insured individual for such month shall be
3 determined without regard to this subsection, and the
4 benefits of all other individuals who are entitled for such
5 month to monthly benefits under section 202 on the
6 wages and self-employment income of such insured in-
7 dividual shall be determined as if no such divorced wife
8 or surviving divorced wife were entitled to benefits for
9 such month.”

10 (7) Section 203 (c) (4) of such Act is amended by
11 striking out “former wife divorced” and inserting in lieu
12 thereof “surviving divorced mother”.

13 (8) Section 203 (d) (1) of such Act is amended by
14 striking out “wife,” and inserting in lieu thereof “wife,
15 divorced wife,”.

16 (9) The second sentence of section 205 (b) of such
17 Act is amended by striking out “wife, widow, former wife
18 divorced,” and inserting in lieu thereof “wife, divorced wife,
19 widow, surviving divorced wife, surviving divorced mother,”.

20 (10) Section 205 (c) (1) (C) of such Act is amended
21 by striking out “former wife divorced,” and inserting in lieu
22 thereof “surviving divorced wife, surviving divorced
23 mother,”.

24 (11) Section 222 (b) (3) of such Act is amended by
25 inserting “divorced wife,” after “wife,”.

1 (e) The amendments made by this section shall be appli-
2 cable with respect to monthly insurance benefits under title
3 II of the Social Security Act beginning with the second
4 month following the month in which this Act is enacted;
5 but, in the case of an individual who was not entitled to a
6 monthly insurance benefit under section 202 of such Act
7 for the first month following the month in which this Act
8 is enacted, only on the basis of an application filed in or
9 after the month in which this Act is enacted.

10 TRANSITIONAL INSURED STATUS

11 SEC. 309. (a) Title II of the Social Security Act is
12 further amended by adding at the end thereof (after the new
13 section 226 added by section 101 of this Act) the following
14 new section:

15 “TRANSITIONAL INSURED STATUS

16 “SEC. 227. (a) In the case of any individual who attains
17 the age of 72 before 1969 but who does not meet the re-
18 quirements of section 214 (a), the 6 quarters of coverage
19 referred to in so much of paragraph (1) of section 214 (a)
20 as follows clause (C) shall, instead, be 3 quarters of cover-
21 age for purposes of determining entitlement of such individual
22 to benefits under section 202 (a), and of his wife to benefits
23 under section 202 (b), but, in the case of such wife, only if
24 she attains the age of 72 before 1969 and only with respect
25 to wife's insurance benefits under section 202 (b) for and

1 after the month in which she attains such age. For each
2 month before the month in which any such individual meets
3 the requirements of section 214 (a), the amount of his old-
4 age insurance benefit shall, notwithstanding the provisions of
5 section 202 (a), be \$35 and the amount of the wife's insur-
6 ance benefit of his wife shall, notwithstanding the provisions
7 of section 202 (b), be \$17.50.

8 “(b) In the case of any individual who has died, who
9 does not meet the requirements of section 214 (a), and whose
10 widow attains age 72 before 1969, the 6 quarters of cover-
11 age referred to in paragraph (3) of section 214 (a) and in
12 so much of paragraph (1) thereof as follows clause (C)
13 shall, for purposes of determining her entitlement to widow's
14 insurance benefits under section 202 (e), instead be—

15 “(1) 3 quarters of coverage if such widow attains
16 the age of 72 in or before 1966,

17 “(2) 4 quarters of coverage if such widow attains
18 the age of 72 in 1967, or

19 “(3) 5 quarters of coverage if such widow attains
20 the age of 72 in 1968.

21 The amount of her widow's insurance benefit for each month
22 shall, notwithstanding the provisions of section 202 (e) (and
23 section 202 (m)), be \$35.

24 “(c) In the case of any individual who becomes, or
25 upon filing application therefor would become, entitled to

1 benefits under section 202 (a) by reason of the application
2 of subsection (a) of this section, who dies, and whose widow
3 attains the age of 72 before 1969, such deceased individual
4 shall be deemed to meet the requirements of subsection (b)
5 of this section for purposes of determining entitlement of such
6 widow to widow's insurance benefits under section 202 (e)."

7 (b) The amendment made by subsection (a) shall
8 apply in the case of monthly benefits under title II of the
9 Social Security Act for and after the second month follow-
10 ing the month in which this Act is enacted on the basis
11 of applications filed in or after the month in which this Act
12 is enacted.

13 INCREASE IN AMOUNT AN INDIVIDUAL IS PERMITTED TO
14 EARN WITHOUT SUFFERING FULL DEDUCTIONS FROM
15 BENEFITS

16 SEC. 310. (a) Paragraph (3) of section 203 (f) of the
17 Social Security Act is amended by striking out "\$500"
18 wherever it appears therein and inserting in lieu thereof
19 "\$1,200".

20 (b) The amendments made by subsection (a) shall
21 apply with respect to taxable years ending after December
22 31, 1965.

23 COVERAGE FOR DOCTORS OF MEDICINE

24 SEC. 311. (a) (1) Section 211 (c) (5) of the Social
25 Security Act is amended to read as follows:

1 “(5) The performance of service by an individual
2 in the exercise of his profession as a Christian Science
3 practitioner.”

4 (2) Section 211 (c) of such Act is further amended by
5 striking out the last two sentences and inserting in lieu
6 thereof the following: “The provisions of paragraph (4) or
7 (5) shall not apply to service (other than service performed
8 by a member of a religious order who has taken a vow of
9 poverty as a member of such order) performed by an in-
10 dividual during the period for which a certificate filed by
11 him under section 1402 (e) of the Internal Revenue Code
12 of 1954 is in effect.”

13 (3) Section 210 (a) (6) (C) (iv) of such Act is
14 amended by inserting before the semicolon at the end thereof
15 the following: “, other than as a medical or dental intern
16 or a medical or dental resident in training”.

17 (4) Section 210 (a) (13) of such Act is amended by
18 striking out all that follows the first semicolon.

19 (b) (1) Section 1402 (c) (5) of the Internal Revenue
20 Code of 1954 (relating to definition of trade or business) is
21 amended to read as follows:

22 “(5) the performance of service by an individual
23 in the exercise of his profession as a Christian Science
24 practitioner.”

25 (2) Section 1402 (c) of such Code is further amended

1 by striking out the last two sentences and inserting in lieu
2 thereof the following: "The provisions of paragraph (4) or
3 (5) shall not apply to service (other than service performed
4 by a member of a religious order who has taken a vow of
5 poverty as a member of such order) performed by an in-
6 dividual during the period for which a certificate filed by
7 him under subsection (e) is in effect."

8 (3) (A) Section 1402 (e) (1) of such Code (relating
9 to filing of waiver certificate by ministers, members of reli-
10 gious orders, and Christian Science practitioners) is amended
11 by striking out "extended to service" and all that follows and
12 inserting in lieu thereof "extended to service described in
13 subsection (c) (4) or (c) (5) performed by him."

14 (B) Clause (A) of section 1402 (e) (2) of such Code
15 (relating to time for filing waiver certificate) is amended
16 to read as follows: "(A) the due date of the return (includ-
17 ing any extension thereof) for his second taxable year ending
18 after 1954 for which he has net earnings from self-employ-
19 ment (computed without regard to subsections (c) (4) and
20 (c) (5)) of \$400 or more, any part of which was derived
21 from the performance of service described in subsection (c)
22 (4) or (c) (5); or".

23 (4) Section 3121 (b) (6) (C) (iv) of such Code (re-
24 lating to definition of employment) is amended by inserting
25 before the semicolon at the end thereof the following: ",

1 other than as a medical or dental intern or a medical or
2 dental resident in training”.

3 (5) Section 3121 (b) (13) of such Code is amended
4 by striking out all that follows the first semicolon.

5 (c) The amendments made by paragraphs (1) and
6 (2) of subsection (a), and by paragraphs (1), (2), and
7 (3) of subsection (b), shall apply only with respect to
8 taxable years ending after December 31, 1965. The amend-
9 ments made by paragraphs (3) and (4) of subsection (a),
10 and by paragraphs (4) and (5) of subsection (b), shall
11 apply only with respect to services performed after 1965.

12 GROSS INCOME OF FARMERS

13 SEC. 312. (a) The second sentence following paragraph
14 (8) in section 211 (a) of the Social Security Act is amended
15 by striking out “\$1,800” each place it appears and inserting
16 in lieu thereof “\$2,400”, and by striking out “\$1,200” each
17 place it appears and inserting in lieu thereof “\$1,600”.

18 (b) The second sentence following paragraph (9) in
19 section 1402 (a) of the Internal Revenue Code of 1954 (re-
20 lating to net earnings from self-employment) is amended
21 by striking out “\$1,800” each place it appears and inserting
22 in lieu thereof “\$2,400”, and by striking out “\$1,200” each
23 place it appears and inserting in lieu thereof “\$1,600”.

24 (c) The amendments made by this section shall apply

1 only with respect to taxable years beginning after December
2 31, 1965.

3
4 **COVERAGE OF TIPS**

5 SEC. 313. (a) (1) Section 209 of the Social Security
6 Act is amended by striking out "or" at the end of subsec-
7 tion (j), by striking out the period at the end of subsection
8 (k) and inserting in lieu thereof "; or", and by adding im-
9 mediately after subsection (k) the following new subsection:

10 " (1) (1) Tips paid in any medium other than cash;

11 " (2) Cash tips received by an employee in any calen-
12 dar month in the course of his employment by an employer
13 unless the amount of such cash tips is \$20 or more."

14 (2) Section 209 of such Act is further amended by
15 adding at the end thereof the following new paragraph:

16 "For purposes of this title, tips received by an employee
17 in the course of his employment shall be considered remun-
18 eration for employment. Such tips shall be deemed to be
19 paid to the employee by the employer and shall be deemed
20 to be so paid at the time a written statement including such
21 tips is furnished to the employer pursuant to section 6053 (a)
22 of the Internal Revenue Code of 1954 or (if no statement
23 including such tips is so furnished) at the time received."

24 (b) Section 451 of the Internal Revenue Code of 1954
25 (relating to general rule for taxable year of inclusion) is
26 amended by adding at the end thereof the following new sub-
section:

1 “(c) SPECIAL RULE FOR EMPLOYEE TIPS.—For pur-
2 poses of subsection (a), tips included in a written statement
3 furnished an employer by an employee pursuant to section
4 6053 (a) shall be deemed to be received at the time the
5 written statement including such tips is furnished to the
6 employer.”

7 (c) (1) Section 3102 of such Code (relating to deduc-
8 tion of tax from wages) is amended by adding at the end
9 thereof the following new subsection:

10 “(c) SPECIAL RULE FOR TIPS.—

11 “(1) In the case of tips which constitute wages,
12 subsection (a) shall be applicable only to such tips as
13 are included in a written statement furnished to the em-
14 ployer pursuant to section 6053 (a), and only to the
15 extent that collection can be made by the employer, at
16 or after the time such statement is so furnished and be-
17 fore the close of the 10th day following the calendar
18 month in which the tips were received, by deducting the
19 amount of the tax from such wages of the employee
20 (excluding tips, but including funds turned over by the
21 employee to the employer pursuant to paragraph (2))
22 as are under control of the employer.

23 “(2) If the tax imposed by section 3101, with re-
24 spect to tips received by an employee during a calendar
25 month which are included in written statements fur-

1 nished to the employer pursuant to section 6053 (a),
2 exceeds the wages of the employee (excluding tips)
3 from which the employer is required to collect the tax
4 under paragraph (1), the employee shall furnish to the
5 employer on or before the 10th day of the following
6 month an amount of money equal to the amount of the
7 excess.

8 “(3) The Secretary or his delegate may, under
9 regulations prescribed by him, authorize employers—

10 “(A) to estimate the amount of tips that will
11 be reported by the employee pursuant to section
12 6053 in any quarter of the calendar year,

13 “(B) to determine the amount to be deducted
14 upon each payment of wages (exclusive of tips)
15 during such quarter as if the tips so estimated
16 constituted the actual tips so reported, and

17 “(C) to deduct upon any payment of wages
18 (other than tips) to such employee during such
19 quarter such amount as may be necessary to adjust
20 the amount actually deducted upon such wages of
21 the employee during the quarter to the amount re-
22 quired to be deducted during the quarter without
23 regard to this paragraph.”

24 (2) The second sentence of section 3102 (a) of such

1 Code is amended by inserting before the period at the end
2 thereof the following: “; and an employer who is furnished
3 by an employee a written statement of tips (received in a
4 calendar month) pursuant to section 6053 (a) to which
5 paragraph (12) (B) of section 3121 (a) is applicable may
6 deduct an amount equivalent to such tax with respect to such
7 tips from any wages of the employee (exclusive of tips)
8 under his control, even though at the time such statement is
9 furnished the total amount of the tips included in statements
10 furnished to the employer as having been received by the
11 employee in such calendar month in the course of his em-
12 ployment by such employer is less than \$20”.

13 (3) Section 3121 (a) of such Code (relating to defini-
14 tion of wages under the Federal Insurance Contributions
15 Act) is amended by striking out “or” at the end of para-
16 graph (10), by striking out the period at the end of para-
17 graph (11) and inserting in lieu thereof “; or ”, and by
18 adding after paragraph (11) the following new paragraph:

19 “(12) (A) tips paid in any medium other than
20 cash;

21 “(B) cash tips received by an employee in any
22 calendar month in the course of his employment by an
23 employer unless the amount of such cash tips is \$20
24 or more.”

1 (4) Section 3121 of such Code is further amended by
2 adding at the end thereof the following new subsection:

3 “(q) TIPS.—For purposes of this chapter, tips received
4 by an employee in the course of his employment shall be
5 considered remuneration for employment. Such tips shall
6 be deemed to be paid to the employee by the employer,
7 and shall be deemed to be so paid at the time a written
8 statement including such tips is furnished to the employer
9 pursuant to section 6053 (a) or (if no statement including
10 such tips is so furnished) at the time received.”

11 (d) (1) Section 3401 of such Code (relating to defi-
12 nitions for purposes of collecting income tax at source on
13 wages) is amended by adding at the end thereof the fol-
14 lowing new subsection:

15 “(f) TIPS.—For purposes of subsection (a), the term
16 ‘wages’ includes tips received by an employee in the course
17 of his employment. Such tips shall be deemed to be paid
18 to the employee by the employer, and shall be deemed to
19 be so paid at the time a written statement including such
20 tips is furnished to the employer pursuant to section 6053 (a)
21 or (if no statement including such tips is so furnished) at
22 the time received.”

23 (2) Section 3401 (a) of such Code (relating to defini-
24 tion of wages for purposes of collecting income tax at
25 source) is amended by striking out “, or” at the end of

1 paragraph (6) and inserting in lieu thereof “; or”, by strik-
2 ing out the period at the end of paragraph (12) and insert-
3 ing in lieu thereof “; or”, by striking out the period at the
4 end of paragraph (15) and inserting in lieu thereof “; or”,
5 and by adding after paragraph (15) the following new
6 paragraph:

7 “(16) (A) as tips in any medium other than cash;
8 “(B) as cash tips to an employee in any calendar
9 month in the course of his employment by an employer
10 unless the amount of such cash tips is \$20 or more.”

11 (3) Subsection (a) of section 3402 of such Code
12 (relating to income tax collected at source) is amended by
13 striking out “subsection (j)” and inserting in lieu thereof
14 “subsections (j) and (k)”.

15 (4) Section 3402 of such Code is further amended by
16 adding at the end thereof the following new subsection:

17 “(k) TIPS.—In the case of tips which constitute wages,
18 subsection (a) shall be applicable only to such tips as are
19 included in a written statement furnished to the employer
20 pursuant to section 6053 (a), and only to the extent that
21 the tax can be deducted and withheld by the employer, at
22 or after the time such statement is so furnished and before
23 the close of the calendar year in which the employee receives
24 the tips which are included in such statement, from such
25 wages of the employee (excluding tips, but including funds

1 turned over by the employee to the employer for the pur-
2 pose of such deduction and withholding) as are under the
3 control of the employer; and an employer who is furnished
4 by an employee a written statement of tips (received in a
5 calendar month) pursuant to section 6053 (a) to which
6 paragraph (16) (B) of section 3401 (a) is applicable may
7 deduct and withhold the tax with respect to such tips from
8 any wages of the employee (excluding tips) under his
9 control, even though at the time such statement is furnished
10 the total amount of the tips included in statements furnished
11 to the employer as having been received by the employee
12 in such calendar month in the course of his employment by
13 such employer is less than \$20. Such tax shall not at any
14 time be deducted and withheld in an amount which exceeds
15 the aggregate of such wages and funds minus any tax re-
16 quired by section 3102 (a) to be collected from such wages.”

17 (e) (1) Section 6051 (a) of such Code (relating to
18 receipts for employees) is amended by adding at the end
19 thereof the following new sentence: “In the case of tips
20 received by an employee in the course of his employment,
21 the amounts required to be shown by paragraph (3) shall
22 include only such tips as are included in statements furnished
23 to the employer pursuant to section 6053 (a); and the
24 amounts required to be shown by paragraph (5) shall include
25 only such tips as are reported by the employee to the em-
26 ployer pursuant to section 6053 (b).”

1 (2) (A) Subpart C of part III of subchapter A of
2 chapter 61 of such Code (relating to information regarding
3 wages paid employees) is amended by adding at the end
4 thereof the following new section:

5 **“SEC. 6053. REPORTING OF TIPS.**

6 “(a) Every employee who, in the course of his employ-
7 ment by an employer, receives in any calendar month tips
8 which are wages (as defined in section 3121 (a) or section
9 3401 (a)) shall report all such tips in one or more written
10 statements furnished to his employer on or before the 10th
11 day following such month. Such statements shall be fur-
12 nished by the employee under such regulations, at such other
13 times before such 10th day, and in such form and manner, as
14 may be prescribed by the Secretary or his delegate.

15 “(b) For purposes of sections 3102 (c) , 3111, 6051
16 (a) , and 6652 (c) , tips received in any calendar month shall
17 be considered reported pursuant to this section only if they
18 are included in such a statement furnished to the employer on
19 or before the 10th day following such month and only to
20 the extent that the tax imposed with respect to such tips
21 by section 3101 can be collected by the employer under
22 section 3102.”

23 (B) The table of sections for such subpart C is amended
24 by adding at the end thereof the following:

“Sec. 6053. Reporting of tips.”

1 (3) Section 6652 of such Code (relating to failure to
2 file certain information returns) is amended by redesignating
3 subsection (c) as subsection (d) and by inserting after sub-
4 section (b) the following new subsection:

5 “(c) FAILURE TO REPORT TIPS.—In the case of tips
6 to which section 6053 (a) applies, if the employee fails to
7 report any of such tips to the employer pursuant to section
8 6053 (b), unless it is shown that such failure is due to
9 reasonable cause and not due to willful neglect, there shall
10 be paid by the employee, in addition to the tax imposed by
11 section 3101 with respect to the amount of the tips which
12 he so failed to report, an amount equal to such tax.”

13 (f) Section 3111 of such Code (relating to rate of tax
14 on employers under the Federal Insurance Contributions
15 Act), as amended by section 321 of this Act, is amended
16 by adding at the end thereof the following new subsection:

17 “(c) TIPS.—In the case of tips which constitute wages,
18 the tax imposed by this section shall be applicable only to
19 such tips as are reported by the employee to the taxpayer
20 pursuant to section 6053 (b).”

21 (g) The amendments made by this section shall apply
22 only with respect to tips received by employees after 1965.

23 INCLUSION OF ALASKA AND KENTUCKY AMONG STATES

24 PERMITTED TO DIVIDE THEIR RETIREMENT SYSTEMS

25 SEC. 314. The first sentence of section 218 (d) (6) (C)
26 of the Social Security Act is amended—

1 (1) by inserting "Alaska," before "California";
2 and

3 (2) by inserting "Kentucky," before "Massachu-
4 setts".

5 ADDITIONAL PERIOD FOR ELECTING COVERAGE UNDER
6 DIVIDED RETIREMENT SYSTEM

7 SEC. 315. The first sentence of section 218 (d) (6) (F)
8 of the Social Security Act is amended by striking out "1963"
9 and inserting in lieu thereof "1967".

10 EMPLOYEES OF NONPROFIT ORGANIZATIONS

11 SEC. 316. (a) (1) Section 3121 (k) (1) (B) (iii) of
12 the Internal Revenue Code of 1954 (relating to effective
13 date of exemption of religious, charitable, and certain other
14 organizations) is amended to read as follows:

15 “(iii) the first day of any calendar quarter
16 preceding the calendar quarter in which the cer-
17 tificate is filed, except that such date may not
18 be earlier than the first day of the twentieth calen-
19 dar quarter preceding the quarter in which such
20 certificate is filed.”

21 (2) The amendment made by paragraph (1) shall
22 apply in the case of any certificate filed under section 3121
23 (k) (1) (A) of such Code after the date of the enactment
24 of this Act.

25 (b) Section 3121 (k) (1) of such Code (relating to

1 waiver of exemption by religious, charitable, and certain
2 other organizations) is further amended by adding at the end
3 thereof the following new subparagraph:

4 “(H) An organization which files a certificate
5 under subparagraph (A) before 1966 may amend
6 such certificate during 1965 or 1966 to make the
7 certificate effective with the first day of any calendar
8 quarter preceding the quarter for which such cer-
9 tificate originally became effective, except that such
10 date may not be earlier than the first day of the
11 twentieth calendar quarter preceding the quarter in
12 which such certificate is so amended.”

13 (c) (1) Section 105 (b) of the Social Security Amend-
14 ments of 1960 is amended to read as follows:

15 “(b) (1) If—

16 “(A) an individual performed service in the
17 employ of an organization with respect to which
18 remuneration was paid before the first day of the
19 calendar quarter in which the organization filed
20 a waiver certificate pursuant to section 3121(k)
21 (1) of the Internal Revenue Code of 1954, and
22 such service is excepted from employment under
23 section 210 (a) (8) (B) of the Social Security Act,

24 - “(B) such service would have constituted em-
25 ployment as defined in section 210 of such Act if

1 the requirements of section 3121 (k) (1) of such
2 Code were satisfied,

3 “(C) such organization paid, on or before the due
4 date of the tax return for the calendar quarter be-
5 fore the calendar quarter in which the organization
6 filed a certificate pursuant to section 3121 (k) (1)
7 of such Code, any amount, as taxes imposed by sec-
8 tions 3101 and 3111 of such Code, with respect to
9 such remuneration paid by the organization to the
10 individual for such service,

11 “(D) such individual, or a fiduciary acting
12 for such individual or his estate, or his survivor
13 (within the meaning of section 205 (c) (1) (C) of
14 such Act), requests that such remuneration be
15 deemed to constitute remuneration for employment
16 for purposes of title II of such Act, and

17 “(E) the request is made in such form and
18 manner, and with such official, as may be pre-
19 scribed by regulations made by the Secretary of
20 Health, Education, and Welfare,

21 then, subject to the conditions stated in paragraphs (2),
22 (3), (4), and (5), the remuneration with respect to which
23 the amount has been paid as taxes shall be deemed to con-
24 stitute remuneration for employment for purposes of title II
25 of such Act.

1 “(2) Paragraph (1) shall not apply with respect to
2 an individual unless the organization referred to in paragraph
3 (1) (A), on or before the date on which the request de-
4 scribed in paragraph (1) is made, has filed a certificate
5 pursuant to section 3121 (k) (1) of such Code.

6 “(3) Paragraph (1) shall not apply with respect to
7 an individual who is employed by the organization referred
8 to in paragraph (2) on the date the certificate is filed.

9 “(4) If credit or refund of any portion of the amount
10 referred to in paragraph (1) (C) (other than a credit or
11 refund which would be allowed if the service constituted
12 employment for purposes of chapter 21 of such Code) has
13 been obtained, paragraph (1) shall not apply with respect
14 to the individual unless the amount credited or refunded
15 (including any interest under section 6611 of such Code)
16 is repaid before January 1, 1968, or, if later, the first day
17 of the third year after the year in which the organization
18 filed a certificate pursuant to section 3121 (k) (1) of such
19 Code.

20 “(5) Paragraph (1) shall not apply to any service
21 performed for the organization in a period for which a
22 certificate filed pursuant to section 3121 (k) (1) of such
23 Code is not in effect.”

24 (2) The amendment made by paragraph (1) shall
25 take effect on the date of the enactment of this Act. The

1 provisions of section 105 (b) of the Social Security Amend-
2 ments of 1960 which were in effect before the date of the
3 enactment of this Act shall be applicable with respect to
4 any request filed under section 105 (b) (1) of such Amend-
5 ments before such date. Nothing in the preceding sentence
6 shall prevent the filing of a request under section 105 (b) (1)
7 of such Amendments as amended by this Act.

8 COVERAGE OF TEMPORARY EMPLOYEES OF THE DISTRICT
9 OF COLUMBIA

10 SEC. 317. (a) Section 210 (a) (7) of the Social Security
11 Act is amended—

12 (1) by striking out “or” at the end of subpara-
13 graph (B),

14 (2) by striking out the semicolon at the end of
15 subparagraph (C) (ii) and inserting in lieu thereof
16 “, or”, and

17 (3) by adding after subparagraph (C) the follow-
18 ing new subparagraph:

19 “(D) service performed in the employ of the Dis-
20 trict of Columbia or any instrumentality which is wholly
21 owned thereby, if such service is not covered by a re-
22 tirement system established by a law of the United
23 States; except that the provisions of this subparagraph
24 shall not be applicable to service performed—

1 “(i) in a hospital or penal institution by a
2 patient or inmate thereof;

3 “(ii) by any individual as an employee in-
4 cluded under section 2 of the Act of August 4,
5 1947 (relating to certain interns, student nurses,
6 and other student employees of hospitals of the
7 District of Columbia Government; 5 U.S.C. 1052),
8 other than as a medical or dental intern or as a
9 medical or dental resident in training;

10 “(iii) by any individual as an employee serving
11 on a temporary basis in case of fire, storm, snow,
12 earthquake, flood, or other similar emergency; or

13 “(iv) by a member of a board, committee, or
14 council of the District of Columbia, paid on a per
15 diem, meeting, or other fee basis;”.

16 (b) Section 3121 (b) (7) of the Internal Revenue Code
17 of 1954 (relating to certain services not included in defini-
18 tion of employment) is amended—

19 (1) by striking out “or” at the end of subpara-
20 graph (A),

21 (2) by striking out the semicolon at the end of
22 subparagraph (B) and inserting in lieu thereof “, or”,
23 and

24 (3) by adding after subparagraph (B) the fol-
25 lowing new subparagraph:

1 “(C) service performed in the employ of the
2 District of Columbia or any instrumentality which is
3 wholly owned thereby, if such service is not covered
4 by a retirement system established by a law of the
5 United States; except that the provisions of this
6 subparagraph shall not be applicable to service
7 performed—

8 “(i) in a hospital or penal institution by a
9 patient or inmate thereof;

10 “(ii) by any individual as an employee in-
11 cluded under section 2 of the Act of August 4,
12 1947 (relating to certain interns, student nurses,
13 and other student employees of hospitals of the
14 District of Columbia Government; 5 U.S.C. 1052),
15 other than as a medical or dental intern or as a
16 medical or dental resident in training;

17 “(iii) by any individual as an employee serv-
18 ing on a temporary basis in case of fire, storm,
19 snow, earthquake, flood or other similar emergency;
20 or

21 “(iv) by a member of a board, committee, or
22 council of the District of Columbia, paid on a per
23 diem, meeting, or other fee basis;”.

24 (c) (1) Section 3125 of such Code (relating to returns

1 in the case of governmental employees in Guam and Amer-
2 ican Samoa) is amended by adding at the end thereof the
3 following new subsection:

4 “(c) DISTRICT OF COLUMBIA.—In the case of the
5 taxes imposed by this chapter with respect to service per-
6 formed in the employ of the District of Columbia or in
7 the employ of any instrumentality which is wholly owned
8 thereby, the return and payment of the taxes may be made
9 by the Commissioners of the District of Columbia or by
10 such agents as they may designate. The person making
11 such return may, for convenience of administration, effective
12 with respect to remuneration paid before 1971, make pay-
13 ments of the tax imposed by section 3111 with respect
14 to such service without regard to the \$5,600 limitation in
15 section 3121 (a) (1) and, effective with respect to remunera-
16 tion paid after 1970, without regard to the \$6,600 limita-
17 tion in such section 3121 (a) (1).”

18 (2) The heading of such section 3125 is
19 amended by striking out “AND AMERICAN SAMOA” and in-
20 serting in lieu thereof “, AMERICAN SAMOA, AND THE
21 DISTRICT OF COLUMBIA”.

22 (3) The table of sections for subchapter C of chapter 21

1 of such Code (relating to general provisions for Federal In-
2 surance Contributions Act) is amended by striking out

“Sec. 3125. Returns in the case of governmental employees
in Guam and American Samoa.”

3 and inserting in lieu thereof

“Sec. 3125. Returns in the case of governmental employees
in Guam, American Samoa, and the District
of Columbia.”

4 (d) Section 6205 (a) of such Code (relating to ad-
5 justment of tax) is amended by adding at the end thereof
6 the following new paragraph:

7 “(4) DISTRICT OF COLUMBIA AS EMPLOYER.—For
8 purposes of this subsection, in the case of remuneration
9 received during any calendar year from the District of
10 Columbia or any instrumentality which is wholly owned
11 thereby, the Commissioners of the District of Columbia
12 and each agent designated by them who makes a return
13 pursuant to section 3125 shall be deemed a separate
14 employer.”

15 (e) Section 6413 (a) of such Code (relating to adjust-
16 ment of certain employment taxes) is amended by adding at
17 the end thereof the following paragraph:

18 “(4) DISTRICT OF COLUMBIA AS EMPLOYER.—For
19 purposes of this subsection, in the case of remuner-

1 ation received during any calendar year from the District
2 of Columbia or any instrumentality which is wholly
3 owned thereby, the Commissioners of the District of
4 Columbia and each agent designated by them who
5 makes a return pursuant to section 3125 shall be deemed
6 a separate employer.”

7 (f) (1) Section 6413 (c) (2) of such Code (relating
8 to applicability of special refunds to certain employment
9 taxes) is amended by adding at the end thereof the follow-
10 ing new subparagraph:

11 “(F) GOVERNMENTAL EMPLOYEES IN THE
12 DISTRICT OF COLUMBIA.—In the case of remunera-
13 tion received from the District of Columbia or any
14 instrumentality wholly owned thereby, during any
15 calendar year, the Commissioners of the District of
16 Columbia and each agent designated by them who
17 makes a return pursuant to section 3125 (c) shall,
18 for purposes of this subsection, be deemed a sepa-
19 rate employer.”

20 (2) The heading of such section 6413 (c) (2) is
21 amended by striking out “AND AMERICAN SAMOA” and in-
22 serting in lieu thereof “, AMERICAN SAMOA, AND THE DIS-
23 TRICT OF COLUMBIA”.

24 (g) The amendments made by this section shall apply
25 with respect to service performed after the calendar quarter

1 in which this section is enacted and after the calendar quar-
2 ter in which the Secretary of the Treasury receives a cer-
3 tification from the Commissioners of the District of Colum-
4 bia expressing their desire to have the insurance system
5 established by title II (and part A of title XVIII) of the
6 Social Security Act extended to the officers and employees
7 coming under the provisions of such amendments.

8 COVERAGE FOR CERTAIN ADDITIONAL HOSPITAL
9 EMPLOYEES IN CALIFORNIA

10 SEC. 318. Section 102(k) of the Social Security
11 Amendments of 1960 is amended by inserting "(1)" im-
12 mediately after "(k)", and by adding at the end thereof
13 the following new paragraph:

14 "(2) Such agreement, as modified pursuant to para-
15 graph (1), may at the option of such State be further
16 modified, at any time prior to the seventh month after the
17 month in which this paragraph is enacted, so as to apply
18 to services performed for any hospital affected by such
19 earlier modification by any individual who after December
20 31, 1959, is or was employed by such State (or any politi-
21 cal subdivision thereof) in any position described in para-
22 graph (1). Such modification shall be effective with re-
23 spect to (A) all services performed by such individual in
24 any such position on or after January 1, 1962, and (B)

1 all such services, performed before such date, with respect
 2 to which amounts equivalent to the sum of the taxes which
 3 would have been imposed by sections 3101 and 3111 of
 4 the Internal Revenue Code of 1954 if such services had
 5 constituted employment for purposes of chapter 21 of such
 6 Code at the time they were performed have, prior to the
 7 date of the enactment of this paragraph, been paid.”

8 TAX EXEMPTION FOR RELIGIOUS GROUPS OPPOSED TO
 9 INSURANCE

10 SEC. 319. (a) Subsection (c) of section 1402 of the
 11 Internal Revenue Code of 1954 is amended by striking out
 12 “or” at the end of paragraph (4), by striking out the period
 13 at the end of paragraph (5) and inserting in lieu thereof
 14 “; or”, and by adding after paragraph (5) the following
 15 new paragraph:

16 “(6) the performance of service by an individual
 17 during the period for which an exemption under subsec-
 18 tion (h) is effective with respect to him.”

19 (b) Subsection (c) of section 211 of the Social Security
 20 Act is amended by striking out “or” at the end of paragraph
 21 (4), by striking out the period at the end of paragraph (5)
 22 and inserting in lieu thereof “; or”, and by adding after
 23 paragraph (5) the following new paragraph:

24 “(6) The performance of service by an individual
 25 during the period for which an exemption under sec-

1 tion 1402 (h) of the Internal Revenue Code of 1954
2 is effective with respect to him.”

3 (c) Section 1402 of the Internal Revenue Code of 1954
4 is further amended by adding at the end thereof the following
5 new subsection:

6 “(h) MEMBERS OF CERTAIN RELIGIOUS FAITHS.—

7 “(1) EXEMPTION.—Any individual may file an ap-
8 plication (in such form and manner, and with such offi-
9 cial, as may be prescribed by regulations under this
10 chapter) for an exemption from the tax imposed by
11 this chapter if he is a member of a recognized religious
12 sect or division thereof and is an adherent of established
13 tenets or teachings of such sect or division by reason of
14 which he is conscientiously opposed to acceptance of the
15 benefits of any private or public insurance which makes
16 payments in the event of death, disability, old-age, or
17 retirement or makes payments toward the cost of, or
18 provides services for, medical care (including the bene-
19 fits of any insurance system established by the Social
20 Security Act). Such exemption may be granted only
21 if the application contains or is accompanied by—

22 “(A) such evidence of such individual’s mem-
23 bership in, and adherence to the tenets or teachings
24 of, the sect or division thereof as the Secretary or his
25 delegate may require for purposes of determining

1 such individual's compliance with the preceding
2 sentence, and

3 “(B) his waiver of all benefits and other pay-
4 ments under titles II and XVIII of the Social Secu-
5 rity Act on the basis of his wages and self-employ-
6 ment income as well as all such benefits and other
7 payments to him on the basis of the wages and self-
8 employment income of any other person,
9 and only if the Secretary of Health, Education, and
10 Welfare finds that—

11 “(C) such sect or division thereof has the estab-
12 lished tenets or teachings referred to in the preced-
13 ing sentence,

14 “(D) it is the practice, and has been for a
15 period of time which he deems to be substantial, for
16 members of such sect or division thereof to make
17 provision for their dependent members which in his
18 judgment is reasonable in view of their general level
19 of living, and

20 “(E) such sect or division thereof has been in
21 existence at all times since December 31, 1950.

22 An exemption may not be granted to any individual if
23 any benefit or other payment referred to in subpara-
24 graph (B) became payable (or, but for section 203 or
25 222 (b) of the Social Security Act, would have become
26 payable) at or before the time of the filing of such waiver.

1 “(2) TIME FOR FILING APPLICATION.—For pur-
2 poses of this subsection, an application must be filed—

3 “(A) In the case of an individual who has
4 self-employment income (determined without re-
5 gard to this subsection and subsection (c) (6)) for
6 any taxable year ending before December 31, 1965,
7 on or before April 15, 1966, and

8 “(B) In any other case, on or before the time
9 prescribed for filing the return (including any exten-
10 sion thereof) for the first taxable year ending on or
11 after December 31, 1965, for which he has self-
12 employment income (as so determined).

13 “(3) PERIOD FOR WHICH EXEMPTION EFFEC-
14 TIVE.—An exemption granted to any individual pur-
15 suant to this subsection shall apply with respect to all
16 taxable years beginning after December 31, 1950, ex-
17 cept that such exemption shall not apply for any taxable
18 year—

19 “(A) beginning (i) before the taxable year in
20 which such individual first met the requirements of
21 the first sentence of paragraph (1), or (ii) before
22 the time as of which the Secretary of Health, Edu-
23 cation, and Welfare finds that the sect or division
24 thereof of which such individual is a member met
25 the requirements of subparagraphs (C) and (D),
26 or

1 “(B) ending (i) after the time such individual
 2 ceases to meet the requirements of the first sentence
 3 of paragraph (1), or (ii) after the time as of which
 4 the Secretary of Health, Education, and Welfare
 5 finds that the sect or division thereof of which he is
 6 a member ceases to meet the requirements of sub-
 7 paragraph (C) or (D).

8 “(4) APPLICATION BY FIDUCIARIES OR SUR-
 9 VIVORS.—In any case where an individual who has self-
 10 employment income dies before the expiration of the
 11 time prescribed by paragraph (2) for filing an appli-
 12 cation for exemption pursuant to this subsection, such
 13 an application may be filed with respect to such indi-
 14 vidual within such time by a fiduciary acting for such
 15 individual's estate or by such individual's survivor
 16 (within the meaning of section 205 (c) (1) (C) of the
 17 Social Security Act).”

18 (d) Section 202 of the Social Security Act is amended
 19 by adding at the end thereof the following new subsection:

20 “Waiver of Benefits

21 “(v) Notwithstanding any other provisions of this title,
 22 in the case of any individual who files a waiver pursuant
 23 to section 1402 (h) of the Internal Revenue Code of
 24 1954 and is granted a tax exemption thereunder, no bene-
 25 fits or other payments shall be payable under this title
 26 to him, no payments shall be made on his behalf under

1 part A of title XVIII, and no benefits or other payments
2 under this title shall be payable on the basis of his wages
3 and self-employment income to any other person, after the
4 filing of such waiver; except that, if thereafter such indi-
5 vidual's tax exemption under such section 1402 (h) ceases
6 to be effective, such waiver shall cease to be applicable in
7 the case of benefits and other payments under this title and
8 part A of title XVIII to the extent based on his self-em-
9 ployment income for and after the first taxable year for
10 which such tax exemption ceases to be effective and on his
11 wages for and after the calendar year (if any) which begins
12 in or with the beginning of such taxable year."

13 (e) The amendments made by this section shall apply
14 with respect to taxable years beginning after December 31,
15 1950. For such purpose, chapter 2 of the Internal Reve-
16 nue Code of 1954 shall be treated as applying to all taxable
17 years beginning after such date.

18 (f) If refund or credit of any overpayment resulting
19 from the enactment of this section is prevented on the date
20 of the enactment of this Act or at any time on or before
21 April 15, 1966, by the operation of any law or rule of law,
22 refund or credit of such overpayment may, nevertheless, be
23 made or allowed if claim therefor is filed on or before April
24 15, 1966. No interest shall be allowed or paid on any over-
25 payment resulting from the enactment of this section.

1 INCREASE OF EARNINGS COUNTED FOR BENEFIT AND TAX

2 PURPOSES

3 SEC. 320. (a) (1) (A) Section 209 (a) (3) of the
4 Social Security Act is amended by inserting "and prior to
5 1966" after "1958".

6 (B) Section 209 (a) of such Act is further amended by
7 adding at the end thereof the following new paragraphs:

8 " (4) That part of remuneration which, after remuneration (other than remuneration referred to in the
9 succeeding subsections of this section) equal to \$5,600
10 with respect to employment has been paid to an indi-
11 vidual during any calendar year after 1965 and prior to
12 1971, is paid to such individual during such calendar
13 year;
14

15 " (5) That part of remuneration which, after remuneration (other than remuneration referred to in the
16 succeeding subsections of this section) equal to \$6,600
17 with respect to employment has been paid to an indi-
18 vidual during any calendar year after 1970, is paid to
19 such individual during such calendar year;".
20

21 (2) (A) Section 211 (b) (1) (C) of such Act is
22 amended by inserting "and prior to 1966" after "1958", and
23 by striking out "; or" and inserting in lieu thereof "; and".

24 (B) Section 211 (b) (1) of such Act is further amended
25 by adding at the end thereof the following new subpara-
26 graphs:

1 “(D) For any taxable year ending after 1965 and
2 prior to 1971, (i) \$5,600, minus (ii) the amount of
3 the wages paid to such individual during the taxable
4 year; and

5 “(E) For any taxable year ending after 1970, (i)
6 \$6,600, minus (ii) the amount of the wages paid to such
7 individual during the taxable year; or”.

8 (3) (A) Section 213 (a) (2) (ii) of such Act is
9 amended by striking out “after 1958” and inserting in lieu
10 thereof “after 1958 and before 1966, or \$5,600 in the case
11 of a calendar year after 1965 and before 1971, or \$6,600 in
12 the case of a calendar year after 1970”.

13 (B) Section 213 (a) (2) (iii) of such Act is amended
14 by striking out “after 1958” and inserting in lieu thereof
15 “after 1958 and before 1966, or \$5,600 in the case of a tax-
16 able year ending after 1965 and before 1971, or \$6,600 in
17 the case of a taxable year ending after 1970”.

18 (4) Section 215 (e) (1) of such Act is amended by
19 striking out “and the excess over \$4,800 in the case of any
20 calendar year after 1958” and inserting in lieu thereof
21 “the excess over \$4,800 in the case of any calendar year
22 after 1958 and before 1966, the excess over \$5,600 in the
23 case of any calendar year after 1965 and before 1971, and
24 the excess over \$6,600 in the case of any calendar year after
25 1970”.

1 (b) (1) (A) Section 1402 (b) (1) (C) of the Internal
2 Revenue Code of 1954 (relating to definition of self-employ-
3 ment income) is amended by inserting “and before 1966”
4 after “1958”, and by striking out “; or” and inserting in
5 lieu thereof “; and”.

6 (B) Section 1402 (b) (1) of such Code is further
7 amended by adding at the end thereof the following new
8 subparagraphs:

9 “(D) for any taxable year ending after 1965
10 and before 1971, (i) \$5,600, minus (ii) the
11 amount of the wages paid to such individual dur-
12 ing the taxable year; and

13 “(E) for any taxable year ending after 1970,
14 (i) \$6,600, minus (ii) the amount of the wages
15 paid to such individual during the taxable year; or”.

16 (2) (A) Section 3121 (a) (1) of such Code (relating
17 to definition of wages) is amended by striking out “\$4,800”
18 each place it appears and inserting in lieu thereof “\$5,600”.

19 (B) Effective with respect to remuneration paid after
20 1970, section 3121 (a) (1) of such Code as amended
21 by subparagraph (A) of this paragraph is amended by
22 striking out “\$5,600” each place it appears and inserting
23 in lieu thereof “\$6,600”.

24 (3) (A) The second sentence of section 3122 of such
25 Code (relating to Federal service) is amended by striking
26 out “\$4,800” and inserting in lieu thereof “\$5,600”.

1 (B) Effective with respect to remuneration paid after
2 1970, such second sentence as amended by subparagraph
3 (A) of this paragraph is amended by striking out "\$5,600"
4 and inserting in lieu thereof "\$6,600".

5 (4) (A) Section 3125 of such Code (relating to re-
6 turns in the case of governmental employees in Guam and
7 American Samoa) is amended by striking out "\$4,800"
8 where it appears in subsections (a) and (b) and inserting
9 in lieu thereof "\$5,600".

10 (B) Effective with respect to remuneration paid after
11 1970, section 3125 of such Code as amended by sub-
12 paragraph (A) of this paragraph is amended by striking
13 out "\$5,600" where it appears in subsections (a) and (b)
14 and inserting in lieu thereof "\$6,600".

15 (5) Section 6413 (c) (1) of such Code (relating to
16 special refunds of employment taxes) is amended—

17 (A) by inserting "and prior to the calendar year
18 1966" after "the calendar year 1958";

19 (B) by inserting after "exceed \$4,800," the follow-
20 ing: "or (C) during any calendar year after the
21 calendar year 1965 and prior to the calendar year
22 1971, the wages received by him during such year
23 exceed \$5,600, or (D) during any calendar year after
24 the calendar year 1970, the wages received by him
25 during such year exceed \$6,600".

1 (C) by inserting before the period at the end
 2 thereof the following: "and before 1966, or which ex-
 3 ceeds the tax with respect to the first \$5,600 of such
 4 wages received in such calendar year after 1965 and
 5 before 1971, or which exceeds the tax with respect to
 6 the first \$6,600 of such wages received in such calendar
 7 year after 1970".

8 (6) Section 6413 (c) (2) (A) of such Code (relating
 9 to refunds of employment taxes in the case of Federal em-
 10 ployees) is amended by striking out "or \$4,800 for any
 11 calendar year after 1958" and inserting in lieu thereof
 12 "\$4,800 for the calendar year 1959, 1960, 1961, 1962,
 13 1963, 1964, or 1965, or \$5,600 for the calendar year
 14 1966, 1967, 1968, 1969, or 1970, or \$6,600 for any cal-
 15 endar year after 1970".

16 (c) The amendments made by subsections (a) (1) and
 17 (a) (3) (A), and the amendments made by subsection (b)
 18 (except paragraph (1) thereof), shall apply only with re-
 19 spect to remuneration paid after December 1965. The
 20 amendments made by subsections (a) (2), (a) (3) (B),
 21 and (b) (1) shall apply only with respect to taxable years
 22 ending after 1965. The amendment made by subsection (a)
 23 (4) shall apply only with respect to calendar years after
 24 1965.

25 CHANGES IN TAX SCHEDULES

26 SEC. 321. (a) Section 1401 of the Internal Revenue

1 Code of 1954 (relating to rate of tax under the Self-Em-
2 ployment Contributions Act) is amended to read as follows:

3 **"SEC. 1401. RATE OF TAX.**

4 " (a) OLD-AGE, SURVIVORS, AND DISABILITY INSUR-
5 ANCE.—In addition to other taxes, there shall be imposed
6 for each taxable year, on the self-employment income of
7 every individual, a tax as follows:

8 " (1) in the case of any taxable year beginning
9 after December 31, 1965, and before January 1, 1969,
10 the tax shall be equal to 6.0 percent of the amount
11 of the self-employment income for such taxable year;

12 " (2) in the case of any taxable year beginning
13 after December 31, 1968, and before January 1, 1973,
14 the tax shall be equal to 6.6 percent of the amount
15 of the self-employment income for such taxable year;
16 and

17 " (3) in the case of any taxable year beginning
18 after December 31, 1972, the tax shall be equal to
19 7.0 percent of the amount of the self-employment
20 income for such taxable year.

21 " (b) HOSPITAL INSURANCE.—In addition to the tax
22 imposed by the preceding subsection, there shall be imposed
23 for each taxable year, on the self-employment income of
24 every individual, a tax as follows:

25 " (1) in the case of any taxable year beginning
26 after December 31, 1965, and before January 1, 1967,

1 the tax shall be equal to 0.35 percent of the amount of
2 the self-employment income for such taxable year;

3 “(2) in the case of any taxable year beginning
4 after December 31, 1966, and before January 1, 1973,
5 the tax shall be equal to 0.50 percent of the amount of
6 the self-employment income for such taxable year;

7 “(3) in the case of any taxable year beginning after
8 December 31, 1972, and before January 1, 1976, the
9 tax shall be equal to 0.55 percent of the amount of the
10 self-employment income for such taxable year;

11 “(4) in the case of any taxable year beginning after
12 December 31, 1975, and before January 1, 1980, the
13 tax shall be equal to 0.60 percent of the amount of the
14 self-employment income for such taxable year;

15 “(5) in the case of any taxable year beginning after
16 December 31, 1979, and before January 1, 1987, the
17 tax shall be equal to 0.70 percent of the amount of the
18 self-employment income for such taxable year; and

19 “(6) in the case of any taxable year beginning after
20 December 31, 1986, the tax shall be equal to 0.80 per-
21 cent of the amount of the self-employment income for
22 such taxable year.

23 For purposes of the tax imposed by this subsection, the ex-
24 clusion of employee representatives by section 1402 (c) (3)
25 shall not apply.”

26 (b) Section 3101 of the Internal Revenue Code of

1 1954 (relating to rate of tax on employees under the
2 Federal Insurance Contributions Act) is amended to read as
3 follows:

4 **"SEC. 3101. RATE OF TAX.**

5 “(a) OLD-AGE, SURVIVORS, AND DISABILITY INSUR-
6 ANCE.—In addition to other taxes, there is hereby imposed
7 on the income of every individual a tax equal to the follow-
8 ing percentages of the wages (as defined in section 3121
9 (a)) received by him with respect to employment (as de-
10 fined in section 3121 (b)) —

11 “(1) with respect to wages received during the
12 calendar years 1966, 1967, and 1968, the rate shall
13 be 4.0 percent;

14 “(2) with respect to wages received during the
15 calendar years 1969, 1970, 1971, and 1972, the rate
16 shall be 4.4 percent; and

17 “(3) with respect to wages received after Decem-
18 ber 31, 1972, the rate shall be 4.8 percent.

19 “(b) HOSPITAL INSURANCE.—In addition to the tax
20 imposed by the preceding subsection, there is hereby imposed
21 on the income of every individual a tax equal to the follow-
22 ing percentages of the wages (as defined in section 3121
23 (a)) received by him with respect to employment (as
24 defined in section 3121 (b) , but without regard to the pro-
25 visions of paragraph (9) thereof insofar as it relates to
26 employees) —

1 “(1) with respect to wages received during the
2 calendar year 1966, the rate shall be 0.35 percent;

3 “(2) with respect to wages received during the
4 calendar years 1967, 1968, 1969, 1970, 1971, and
5 1972, the rate shall be 0.50 percent;

6 “(3) with respect to wages received during the
7 calendar years 1973, 1974, and 1975, the rate shall be
8 0.55 percent;

9 “(4) with respect to wages received during the
10 calendar years 1976, 1977, 1978, and 1979, the rate
11 shall be 0.60 percent;

12 “(5) with respect to wages received during the
13 calendar years 1980, 1981, 1982, 1983, 1984, 1985,
14 and 1986, the rate shall be 0.70 percent; and

15 “(6) with respect to wages received after Decem-
16 ber 31, 1986, the rate shall be 0.80 percent.”

17 (c) Section 3111 of the Internal Revenue Code of
18 1954 (relating to rate of tax on employers under the Federal
19 Insurance Contributions Act) is amended to read as follows:
20 “SEC. 3111. RATE OF TAX.

21 “(a) OLD-AGE, SURVIVORS, AND DISABILITY INSUR-
22 ANCE.—In addition to other taxes, there is hereby imposed
23 on every employer an excise tax, with respect to having
24 individuals in his employ, equal to the following percentages
25 of the wages (as defined in section 3121 (a)) paid by him

1 with respect to employment (as defined in section 3121
2 (b)) —

3 “(1) with respect to wages paid during the calen-
4 dar years 1966, 1967, and 1968, the rate shall be 4.0
5 percent;

6 “(2) with respect to wages paid during the calen-
7 dar years 1969, 1970, 1971, and 1972, the rate shall
8 be 4.4 percent; and

9 “(3) with respect to wages paid after December 31,
10 1972, the rate shall be 4.8 percent.

11 “(b) HOSPITAL INSURANCE.—In addition to the tax
12 imposed by the preceding subsection, there is hereby
13 imposed on every employer an excise tax, with respect to
14 having individuals in his employ, equal to the following
15 percentages of the wages (as defined in section 3121(a))
16 paid by him with respect to employment (as defined in sec-
17 tion 3121(b) , but without regard to the provisions of para-
18 graph (9) thereof insofar as it relates to employees) —

19 “(1) with respect to wages paid during the cal-
20 endar year 1966, the rate shall be 0.35 percent;

21 “(2) with respect to wages paid during the cal-
22 endar years 1967, 1968, 1969, 1970, 1971, and 1972,
23 the rate shall be 0.50 percent;

24 “(3) with respect to wages paid during the cal-

1 endar years 1973, 1974, and 1975, the rate shall be
2 0.55 percent;

3 “(4) with respect to wages paid during the calendar
4 years 1976, 1977, 1978, and 1979, the rate shall be
5 0.60 percent;

6 “(5) with respect to wages paid during the cal-
7 endar years 1980, 1981, 1982, 1983, 1984, 1985,
8 and 1986, the rate shall be 0.70 percent;

9 “(6) with respect to wages paid after December
10 31, 1986, the rate shall be 0.80 percent.”

11 (d) The amendments made by subsection (a) shall
12 apply only with respect to taxable years beginning after
13 December 31, 1965. The amendments made by subsections
14 (b) and (c) shall apply only with respect to remuneration
15 paid after December 31, 1965.

16 REIMBURSEMENT OF TRUST FUNDS FOR COST OF NONCON-
17 TRIBUTORY MILITARY SERVICE CREDITS

18 SEC. 322. Section 217 (g) of the Social Security Act is
19 amended to read as follows:

20 “(g) (1) In September 1965, and in every fifth Sep-
21 tember thereafter up to and including September 2010, the
22 Secretary shall determine the amount which, if paid in
23 equal installments at the beginning of each fiscal year in
24 the period beginning—

25 “(A) with July 1, 1965, in the case of the first
26 such determination, and

1 “(B) with the July 1 following the determination
2 in the case of all other such determinations,
3 and ending with the close of June 30, 2015, would accumu-
4 late, with interest compounded annually, to an amount
5 equal to the amount needed to place each of the Trust Funds
6 and the Federal Hospital Insurance Trust Fund in the same
7 position at the close of June 30, 2015, as he estimates they
8 would otherwise be in at the close of that date if section
9 210 of this Act as in effect prior to the Social Security Act
10 Amendments of 1950, and this section, had not been en-
11 acted. The rate of interest to be used in determining such
12 amount shall be the rate determined under section 201 (d)
13 for public-debt obligations which were or could have been
14 issued for purchase by the Trust Funds in the June preceding
15 the September in which such determination is made.

16 “(2) There are authorized to be appropriated to the
17 Trust Funds and the Federal Hospital Insurance Trust
18 Fund—

19 “(A) for the fiscal year ending June 30, 1966,
20 an amount equal to the amount determined under para-
21 graph (1) in September 1965, and

22 “(B) for each fiscal year in the period beginning
23 with July 1, 1966, and ending with the close of June 30,
24 2015, an amount equal to the annual installment for
25 such fiscal year under the most recent determination
26 under paragraph (1) which precedes such fiscal year.

1 “(3) For the fiscal year ending June 30, 2016, there
 2 is authorized to be appropriated to the Trust Funds and
 3 the Federal Hospital Insurance Trust Fund such sums as
 4 the Secretary determines would place the Trust Funds and
 5 the Federal Hospital Insurance Trust Fund in the same
 6 position in which they would have been at the close of
 7 June 30, 2015, if section 210 of this Act as in effect
 8 prior to the Social Security Act Amendments of 1950, and
 9 this section, had not been enacted.

10 “(4) There are authorized to be appropriated to the
 11 Trust Funds and the Federal Hospital Insurance Trust Fund
 12 annually, as benefits under this title and part A of title
 13 XVIII are paid after June 30, 2015, such sums as the Sec-
 14 retary determines to be necessary to meet the additional
 15 costs, resulting from subsections (a), (b), and (e), of such
 16 benefits (including lump-sum death payments).”

17 ADOPTION OF CHILD BY RETIRED WORKER

18 SEC. 323. (a) Section 202 (d) of the Social Security
 19 Act is amended—

20 (1) by striking out the last sentence in paragraph
 21 (1), and

22 (2) by adding at the end thereof (after the new
 23 paragraphs added by section 306 of this Act) the fol-
 24 lowing new paragraphs:

25 “(9) In the case of—

1 “(A) an individual entitled to disability insurance
2 benefits, or

3 “(B) an individual entitled to old-age insurance
4 benefits who was entitled to disability insurance benefits
5 for the month preceding the first month for which he
6 was entitled to old-age insurance benefits,

7 clauses (i) and (iii) of paragraph (1) (C) shall not apply
8 to a child of such individual unless such child—

9 “(C) is the natural child or stepchild of such in-
10 dividual (including such a child who was legally adopted
11 by such individual), or

12 “(D) was legally adopted by such individual be-
13 fore the end of the 24-month period beginning with
14 the month after the month in which such individual
15 most recently became entitled to disability insurance
16 benefits, but only if—

17 “(i) proceedings for such adoption of the child
18 had been instituted by such individual in or before
19 the month in which began the period of disability
20 of such individual which still exists at the time of
21 such adoption, or

22 “(ii) such adopted child was living with such
23 individual in such month.

24 “(10) In the case of an individual entitled to old-age
25 insurance benefits (but not an individual included under

1 paragraph (9)), clauses (i) and (iii) of paragraph (1)
2 (C) shall not apply to a child of such individual unless such
3 child—

4 “(A) is the natural child or stepchild of such in-
5 dividual (including such a child who was legally adopted
6 by such individual) , or

7 “(B) was legally adopted by such individual be-
8 fore the end of the 24-month period beginning with
9 the month after the month in which such individual
10 became entitled to old-age insurance benefits, but only
11 if—

12 “(i) such child had been receiving at least
13 one-half of his support from such individual for
14 the year before such individual filed his application
15 for old-age insurance benefits or, if such individual
16 had a period of disability which continued until he
17 had become entitled to old-age insurance benefits, for
18 the year before such period of disability began, and

19 “(ii) either proceedings for such adoption of
20 the child had been instituted by such individual in
21 or before the month in which the individual filed his
22 application for old-age insurance benefits or such
23 adopted child was living with such individual in such
24 month.”

25 (b) The amendments made by subsection (a) of this
26 section shall be applicable to persons who file applications, or

1 on whose behalf applications are filed, for benefits under sec-
 2 tion 202 (d) of the Social Security Act on or after the date
 3 this section is enacted. The time limit provided by section
 4 202 (d) (10) (B) of such Act as amended by this section for
 5 legally adopting a child shall not apply in the case of any
 6 child who is adopted before the end of the 12-month period
 7 following the month in which this section is enacted.

8 EXTENSION OF PERIOD FOR FILING PROOF OF SUPPORT
 9 AND APPLICATIONS FOR LUMP-SUM DEATH PAYMENT

10 SEC. 324. (a) Section 202 (p) of the Social Security
 11 Act is amended to read as follows:

12 “Extension of Period for Filing Proof of Support and
 13 Applications for Lump-Sum Death Payment

14 “(p) In any case in which there is a failure—

15 “(1) to file proof of support under subparagraph
 16 (C) of subsection (c) (1), clause (i) or (ii) of sub-
 17 paragraph (D) of subsection (f) (1), or subparagraph
 18 (B) of subsection (h) (1), or under clause (B) of
 19 subsection (f) (1) of this section as in effect prior to
 20 the Social Security Act Amendments of 1950, within
 21 the period prescribed by such subparagraph or clause, or

22 “(2) to file, in the case of a death after 1946,
 23 application for a lump-sum death payment under sub-
 24 section (i), or under subsection (g) of this section as
 25 in effect prior to the Social Security Act Amendments
 26 of 1950, within the period prescribed by such subsection,

1 any such proof or application, as the case may be, which is
2 filed after the expiration of such period shall be deemed to
3 have been filed within such period if it is shown to the satis-
4 faction of the Secretary that there was good cause for failure
5 to file such proof or application within such period. The
6 determination of what constitutes good cause for purposes
7 of this subsection shall be made in accordance with regula-
8 tions of the Secretary.”

9 (b) The amendments made by this section shall be
10 effective with respect to (1) applications for lump-sum death
11 payments filed in or after the month in which this Act is
12 enacted, and (2) monthly benefits based on applications
13 filed in or after such month.

14 TREATMENT OF CERTAIN ROYALTIES FOR RETIREMENT
15 TEST PURPOSES

16 SEC. 325. (a) (1) Subparagraph (B) of section 203
17 (f) (5) of the Social Security Act is amended to read as
18 follows:

19 “(B) For purposes of this section—

20 “(i) an individual’s net earnings from self-
21 employment for any taxable year shall be deter-
22 mined as provided in section 211, except that
23 paragraphs (1), (4), and (5) of section 211(c)
24 shall not apply and the gross income shall be com-
25 puted by excluding the amounts provided by sub-
26 paragraph (D), and

1 “(ii) an individual’s net loss from self-employ-
2 ment for any taxable year is the excess of the de-
3 ductions (plus his distributive share of loss described
4 in section 702 (a) (9) of the Internal Revenue
5 Code of 1954) taken into account under clause (i)
6 over the gross income (plus his distributive share
7 of income so described) taken into account under
8 clause (i).”

9 (2) Such section 203 (f) (5) is further amended by
10 adding at the end thereof the following new subparagraph:

11 “(D) In the case of an individual—

12 “(i) who has attained the age of 65 on or be-
13 fore the last day of the taxable year, and

14 “(ii) who shows to the satisfaction of the Sec-
15 retary that he is receiving royalties attributable to
16 a copyright or patent obtained before the taxable
17 year in which he attained the age of 65 and that
18 the property to which the copyright or patent re-
19 lates was created by his own personal efforts,
20 there shall be excluded from gross income any such
21 royalties.”

22 (b) The amendments made by subsection (a) shall
23 apply with respect to the computation of net earnings from
24 self-employment and the net loss from self-employment for
25 taxable years beginning after 1964.

1 AMENDMENTS PRESERVING RELATIONSHIP BETWEEN RAIL-
 2 ROAD RETIREMENT AND OLD-AGE, SURVIVORS, AND DIS-
 3 ABILITY INSURANCE SYSTEMS

4 SEC. 326. (a) Section 1 (q) of the Railroad Retire-
 5 ment Act of 1937 is amended by striking out "1961" and
 6 inserting in lieu thereof "1965".

7 (b) Section 5 (l) (9) of such Act is amended by strik-
 8 ing out "after 1958 is less than \$4,800" and inserting in lieu
 9 thereof the following: "after 1958 and before 1966 is less
 10 than \$4,800, or for any calendar year after 1965 and be-
 11 fore 1971 is less than \$5,600, or for any calendar year
 12 after 1970 is less than \$6,600"; and by striking out "and
 13 \$4,800 for years after 1958", and inserting in lieu thereof
 14 the following: "\$4,800 for years after 1958 and before
 15 1966, \$5,600 for years after 1965 and before 1971, and
 16 \$6,600 for years after 1970".

17 TECHNICAL AMENDMENT RELATING TO MEETINGS OF BOARD
 18 OF TRUSTEES OF THE OLD-AGE, SURVIVORS, AND DIS-
 19 ABILITY INSURANCE TRUST FUNDS

20 SEC. 327. Section 201 (c) of the Social Security Act
 21 is amended by striking out "six months" in the fourth sen-
 22 tence and inserting in lieu thereof "calendar year".

23 TITLE IV—PUBLIC ASSISTANCE AMENDMENTS
 24 INCREASED FEDERAL PAYMENTS UNDER PUBLIC ASSIST-
 25 ANCE TITLES OF THE SOCIAL SECURITY ACT

26 SEC. 401. (a) Section 3 (a) (1) of the Social Security
 27 Act is amended (1) by striking out, in so much thereof as

1 precedes clause (A), "during such quarter" and inserting in
2 lieu thereof "during each month of such quarter"; (2) by
3 striking out, in clause (A), "29/35", "any month", and
4 "\$35" and inserting in lieu thereof "31/37", "such month",
5 and "\$37", respectively; and (3) by striking out clauses
6 (B) and (C) and inserting in lieu thereof the following:

7 " (B) the larger of the following:

8 " (i) (I) the Federal percentage (as defined
9 in section 1101 (a) (8)) of the amount by which
10 such expenditures exceed the amount which may be
11 counted under clause (A), not counting so much of
12 such excess with respect to such month as exceeds
13 the product of \$38 multiplied by the total number
14 of recipients of old-age assistance for such month,
15 plus (II) 15 per centum of the total expended dur-
16 ing such month as old-age assistance under the State
17 plan in the form of medical or any other type of
18 remedial care, not counting so much of such ex-
19 penditure with respect to such month as exceeds the
20 product of \$15 multiplied by the total number of
21 recipients of old-age assistance for such month, or

22 " (ii) (I) the Federal medical percentage (as
23 defined in section 6 (c)) of the amount by which
24 such expenditures exceed the maximum which may
25 be counted under clause (A), not counting so much
26 of any expenditures with respect to such month as
27 exceeds (a) the product of \$52 multiplied by the

1 total number of such recipients of old-age assistance
 2 for such month, or (b) if smaller, the total ex-
 3 pended as old-age assistance in the form of medical
 4 or any other type of remedial care with respect to
 5 such month plus the product of \$37 multiplied by
 6 such total number of such recipients, plus (II) the
 7 Federal percentage of the amount by which the
 8 total expended during such month as old-age as-
 9 sistance under the State plan exceeds the amount
 10 which may be counted under clause (A) and the
 11 preceding provisions of this clause (B) (ii), not
 12 counting so much of such excess with respect to such
 13 month as exceeds the product of \$38 multiplied by
 14 the total number of such recipients of old-age as-
 15 sistance for such month;”.

16 (b) Section 1603 (a) (1) of such Act is amended (1)
 17 by striking out, in so much thereof as precedes clause (A),
 18 “during such quarter” and inserting in lieu thereof “during
 19 each month of such quarter”; (2) by striking out, in clause
 20 (A), “29/35”, “any month”, and “\$35” and inserting in
 21 lieu thereof “31/37”, “such month”, and “\$37”, respec-
 22 tively; and (3) by striking out clauses (B) and (C) and
 23 inserting in lieu thereof the following:

24 “(B) the larger of the following:

25 “(i) (I) the Federal percentage (as defined
 26 in section 1101 (a) (8)) of the amount by which

1 such expenditures exceed the amount which may be
2 counted under clause (A), not counting so much
3 of such excess with respect to such month as ex-
4 ceeds the product of \$38 multiplied by the total
5 number of recipients of aid to the aged, blind, or
6 disabled for such month, plus (II) 15 per centum
7 of the total expended during such month as aid to
8 the aged, blind, or disabled under the State plan in
9 the form of medical or any other type of remedial
10 care, not counting so much of such expenditure with
11 respect to such month as exceeds the product of \$15
12 multiplied by the total number of recipients of aid to
13 the aged, blind, or disabled for such month, or

14 “(ii) (I) the Federal medical percentage (as
15 defined in section 6(c)) of the amount by which
16 such expenditures exceed the maximum which may
17 be counted under clause (A), not counting so much
18 of any expenditures with respect to such month as
19 exceeds (a) the product of \$52 multiplied by the
20 total number of such recipients of aid to the aged,
21 blind, or disabled for such month, or (b) if smaller,
22 the total expended as aid to the aged, blind, or dis-
23 abled in the form of medical or any other type of
24 remedial care with respect to such month plus the
25 product of \$37 multiplied by such total number
26 of such recipients, plus (II) the Federal percentage

1 of the amount by which the total expended during
 2 such month as aid to the aged, blind, or disabled
 3 under the State plan exceeds the amount which
 4 may be counted under clause (A) and the preced-
 5 ing provisions of this clause (B) (ii), not counting
 6 so much of such excess with respect to such month
 7 as exceeds the product of \$38 multiplied by the
 8 total number of such recipients of aid to the aged,
 9 blind, or disabled for such month;”.

10 (c) Section 403 (a) (1) of such Act is amended (1) by
 11 striking out “fourteen-seventeenths” and “\$17” in clause
 12 (A) and inserting in lieu thereof “five-sixths” and “\$18”,
 13 respectively; and (2) by striking out “\$30” in clause (B)
 14 and inserting in lieu thereof “\$32”.

15 (d) Section 1003 (a) (1) of such Act is amended (1)
 16 by striking out, in clause (A), “29/35” and “\$35” and
 17 inserting in lieu thereof “31/37” and “\$37”, respectively;
 18 and (2) by striking out, in clause (B), “\$70” and insert-
 19 ing in lieu thereof “\$75”.

20 (e) Section 1403 (a) (1) of such Act is amended (1)
 21 by striking out, in clause (A), “29/35” and “\$35” and
 22 inserting in lieu thereof “31/37” and “\$37”, respectively;
 23 and (2) by striking out, in clause (B), “\$70” and inserting
 24 in lieu thereof “\$75”.

25 (f) The amendments made by this section shall apply
 26 in the case of expenditures made after December 31, 1965,

1 under a State plan approved under title I, IV, X, XIV or
2 XVI of the Social Security Act.

3 PROTECTIVE PAYMENTS

4 SEC. 402. (a) Section 6 (a) of the Social Security Act
5 (as amended by section 221 of this Act) is amended by add
6 ing at the end thereof the following new sentence: "Such
7 term also includes payments which are not included within
8 the meaning of such term under the preceding sentence, but
9 which would be so included except that they are made on
10 behalf of such a needy individual to another individual who
11 (as determined in accordance with standards prescribed by
12 the Secretary) is interested in or concerned with the welfare
13 of such needy individual, but only with respect to a State
14 whose State plan approved under section 2 includes provi-
15 sion for—

16 " (1) determination by the State agency that such
17 needy individual has, by reason of his physical or
18 mental condition, such inability to manage funds that
19 making payments to him would be contrary to his wel-
20 fare and, therefore, it is necessary to provide such
21 assistance through payments described in this sentence;

22 " (2) making such payments only in cases in which
23 such payments will, under the rules otherwise applicable
24 under the State plan for determining need and the
25 amount of old-age assistance to be paid (and in con-
26 junction with other income and resources), meet all the

1 need of the individuals with respect to whom such pay-
2 ments are made;

3 “(3) undertaking and continuing special efforts to
4 protect the welfare of such individual and to improve,
5 to the extent possible, his capacity for self-care and to
6 manage funds;

7 “(4) periodic review by such State agency of the
8 determination under paragraph (1) to ascertain whether
9 conditions justifying such determination still exist, with
10 provision for termination of such payments if they do not
11 and for seeking judicial appointment of a guardian or
12 other legal representative, as described in section 1111,
13 if and when it appears that such action will best serve
14 the interests of such needy individual; and

15 “(5) opportunity for a fair hearing before the State
16 agency on the determination referred to in paragraph
17 (1) for any individual with respect to whom it is made.”

18 (b) Section 1605 (a) of such Act (as amended by sec-
19 tion 221 of this Act) is amended by adding at the end
20 thereof (after and below paragraph (2)) the following new
21 sentence:

22 “Such term also includes payments which are not included
23 within the meaning of such term under the preceding sen-
24 tence, but which would be so included except that they are
25 made on behalf of such a needy individual to another in-

1 dividual who (as determined in accordance with standards
2 prescribed by the Secretary) is interested in or concerned
3 with the welfare of such needy individual, but only with re-
4 spect to a State whose State plan approved under section
5 1602 includes provision for—

6 “(A) determination by the State agency that such
7 needy individual has, by reason of his physical or mental
8 condition, such inability to manage funds that making
9 payments to him would be contrary to his welfare and,
10 therefore, it is necessary to provide such aid through
11 payments described in this sentence;

12 “(B) making such payments only in cases in which
13 such payments will, under the rules otherwise applicable
14 under the State plan for determining need and the
15 amount of aid to the aged, blind, or disabled to be paid
16 (and in conjunction with other income and resources),
17 meet all the need of the individuals with respect to
18 whom such payments are made;

19 “(C) undertaking and continuing special efforts to
20 protect the welfare of such individual and to improve,
21 to the extent possible, his capacity for self-care and to
22 manage funds;

23 “(D) periodic review by such State agency of the
24 determination under clause (A) to ascertain whether

1 conditions justifying such determination still exist, with
2 provision for termination of such payments if they do not
3 and for seeking judicial appointment of a guardian or
4 other legal representative, as described in section 1111,
5 if and when it appears that such action will best serve
6 the interests of such needy individual; and

7 “(E) opportunity for a fair hearing before the State
8 agency on the determination referred to in clause (A)
9 for any individual with respect to whom it is made.”

10 (c) The amendments made by this section shall apply
11 in the case of expenditures made after December 31, 1965,
12 under a State plan approved under title I or XVI of the
13 Social Security Act.

14 DISREGARDING CERTAIN EARNINGS IN DETERMINING NEED
15 UNDER ASSISTANCE PROGRAMS FOR THE AGED

16 SEC. 403. (a) Effective January 1, 1966, section 2
17 (a) (10) (A) of the Social Security Act is amended by
18 striking out “; except that, in making such determination,
19 of the first \$50 per month of earned income the State agency
20 may disregard, after December 31, 1962, not more than
21 the first \$10 thereof plus one-half of the remainder” and
22 inserting in lieu thereof the following: “; except that, in
23 making such determination, of the first \$80 per month of
24 earned income the State agency may disregard not more
25 than the first \$20 thereof plus one-half of the remainder”.

26 (b) Effective January 1, 1966, section 1602 (a) (14)

1 of such Act is amended by striking out "of the first \$50 per
 2 month of earned income the State agency may, after Decem-
 3 ber 31, 1962, disregard not more than the first \$10 thereof
 4 plus one-half of the remainder" and inserting in lieu thereof
 5 the following: "of the first \$80 per month of earned income
 6 the State agency may disregard not more than the first \$20
 7 thereof plus one-half of the remainder".

8 ADMINISTRATIVE AND JUDICIAL REVIEW OF PUBLIC
 9 ASSISTANCE DETERMINATIONS

10 SEC. 404. (a) Title XI of the Social Security Act is
 11 amended by adding at the end thereof the following new
 12 section:

13 "ADMINISTRATIVE AND JUDICIAL REVIEW OF CERTAIN
 14 ADMINISTRATIVE DETERMINATIONS

15 "SEC. 1116. (a) (1) Whenever a State plan is sub-
 16 mitted to the Secretary by a State for approval under title I,
 17 IV, X, XIV, XVI, or XIX, he shall, not later than 90 days
 18 after the date the plan is submitted to him, make a deter-
 19 mination as to whether it conforms to the requirements for
 20 approval under such title. The 90-day period provided
 21 herein may be extended by written agreement of the Secre-
 22 tary and the affected State.

23 "(2) Any State dissatisfied with a determination of the
 24 Secretary under paragraph (1) with respect to any plan
 25 may, within 60 days after it has been notified of such deter-
 26 mination, file a petition with the Secretary for reconsidera-

tion of the issue of whether such plan conforms to the requirements for approval under such title. Upon receipt of such a petition, the Secretary shall notify the State of the time and place at which a hearing will be held for the purpose of reconsidering such issue. Such hearing shall be held not less than 20 days nor more than 60 days after the date notice of such hearing is furnished to such State, unless the Secretary and such State agree in writing to holding the hearing at another time. The Secretary shall affirm, modify, or reverse his original determination within 60 days of the conclusion of the hearing.

“(3) Any State which is dissatisfied with a final determination made by the Secretary on such a reconsideration or a final determination of the Secretary under section 4, 404, 1004, 1404, 1604, or 1904 may, within 60 days after notice of such determination, file with the United States court of appeals for the circuit in which such State is located a petition for review of such determination. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary. The Secretary thereupon shall file in the court the record of the proceedings on which he based his determination as provided in section 2112 of title 28, United States Code.

“(4) The findings of fact by the Secretary, unless substantially contrary to the weight of the evidence, shall be conclusive; but the court, for good cause shown, may remand

1 the case to the Secretary to take further evidence, and the
2 Secretary may thereupon make new or modified findings of
3 fact and may modify his previous action, and shall certify
4 to the court the transcript and record of the further proceed-
5 ings. Such new or modified findings of fact shall likewise
6 be conclusive unless substantially contrary to the weight of
7 the evidence.

8 “(5) The court shall have jurisdiction to affirm the
9 action of the Secretary or to set it aside, in whole or in part.
10 The judgment of the court shall be subject to review by
11 the Supreme Court of the United States upon certiorari or
12 certification as provided in section 1254 of title 28, United
13 States Code.

14 “(b) For the purposes of subsection (a), any amend-
15 ment of a State plan approved under title I, IV, X, XIV,
16 XVI, or XIX may, at the option of the State, be treated
17 as the submission of a new State plan.

18 “(c) Action pursuant to an initial determination of the
19 Secretary described in subsection (a) or (b) shall not be
20 stayed pending reconsideration, but in the event that the
21 Secretary subsequently determines that his initial determi-
22 nation was incorrect he shall certify restitution forthwith in
23 a lump sum of any funds incorrectly withheld or otherwise
24 denied.

25 “(d) Whenever the Secretary determines that any item

1 or class of items on account of which Federal financial partici-
 2 pation is claimed under title I, IV, X, XIV, XVI, or XIX
 3 shall be disallowed for such participation, the State shall be
 4 entitled to and upon request shall receive a reconsideration
 5 of the disallowance.”

6 (b) The amendment made by subsection (a) shall
 7 apply only with respect to determinations made after
 8 December 31, 1965.

9 MAINTENANCE OF STATE PUBLIC ASSISTANCE

10 EXPENDITURES

11 SEC. 405. Title XI of the Social Security Act is
 12 amended by adding at the end thereof (after the new sec-
 13 tion 1116 added by section 404 of this Act) the following
 14 new section:

15 “MAINTENANCE OF STATE EFFORT

16 “SEC. 1117. (a) The total of the amounts determined
 17 under sections 3, 403, 1003, 1403, 1603, and 1903 for
 18 any State for any quarter beginning after December 31,
 19 1965, and ending before July 1, 1969, shall be reduced
 20 to the extent that—

21 “(1) the excess of (A) the total of the amounts
 22 determined for the State under sections 3, 403, 1003,
 23 1403, 1603, and 1903 for such quarter over (B) the
 24 total of the amounts determined for the State under sec-
 25 tions 3, 403, 1003, 1403, and 1603 for the same quarter
 26 of the fiscal year ending June 30, 1965, is greater than

1 “(2) the excess of (A) the total of the expenditures
2 for such quarter (for which the determination is being
3 made) under the plans of the State approved under
4 titles I, IV, X, XIV, XVI, and XIX over (B)
5 the total of the expenditures under the State plans of the
6 State approved under titles I, IV, X, XIV, and XVI
7 for the same quarter of the fiscal year ending June 30,
8 1965;

9 except that, at the option of the State, any of the following
10 may be substituted (with respect to the quarters of any
11 fiscal year) for the amount determined as provided in
12 paragraph (1) (B) —

13 “(3) the total of the amounts determined for the
14 State under sections 3, 403, 1003, 1403, and 1603 for
15 the same quarter in the fiscal year ending June 30,
16 1964; or

17 “(4) the average of the totals determined for the
18 State under sections 3, 403, 1003, 1403, and 1603 for
19 each quarter in the fiscal year ending June 30, 1964, or
20 June 30, 1965.

21 If the substitution of the total referred to in paragraph (3)
22 is chosen by the State, there shall be substituted for the
23 amount determined under clause (B) of paragraph (2)
24 the total of the expenditures under the plans of the State
25 approved under titles I, IV, X, XIV, and XVI for the

1 quarter referred to in such paragraph (3). If the substi-
2 tution of the average for either of the years referred to in par-
3 agraph (4) is chosen by the State, there shall be substituted
4 for the amount determined under clause (B) of paragraph
5 (2) the average of the total expenditures under the plans
6 of the State approved under titles I, IV, X, XIV, and XVI
7 for each quarter in the same fiscal year.

8 “(b) For purposes of this section, expenditures under
9 the plans of any State approved under titles I, IV, X,
10 XIV, XVI, and XIX and the reduction determined with
11 respect thereto under this section, shall be determined on
12 the basis of data furnished by the State in the quarterly
13 reports submitted by the State to the Secretary pursuant to
14 and in accordance with the requirements of the Secretary
15 under title I, IV, X, XIV, XVI, or XIX; and determina-
16 tions so made shall be conclusive for purposes of this section.

17 “(c) If a reduction is required under the preceding
18 provisions of this section in the total of the amounts deter-
19 mined for a State under sections 3, 403, 1003, 1403, 1603,
20 and 1903 for any quarter, the Secretary shall determine
21 which of such amounts shall be reduced and the extent
22 thereof in such manner as in his judgment will best carry
23 out the purpose of maintaining State effort under the Federal-
24 State public assistance programs of the State, and with the

1 total of such reductions to be equal to the reduction required
 2 under subsections (a) and (b) of this section.”

3 DISREGARDING OASDI BENEFIT INCREASE, AND CHILD’S
 4 INSURANCE BENEFIT PAYMENTS BEYOND AGE 18, TO
 5 THE EXTENT ATTRIBUTABLE TO RETROACTIVE EFFEC-
 6 TIVE DATE

7 SEC. 406. Notwithstanding the provisions of sections
 8 2 (a) (10), 402 (a) (7), 1002 (a) (8), 1402 (a) (8), and
 9 1602 (a) (14) of the Social Security Act, a State may disre-
 10 gard, in determining need for aid or assistance under a State
 11 plan approved under title I, IV, X, XIV, or XVI of such
 12 Act, any amount paid to any individual under title II of such
 13 Act, for months prior to the month in which payment of
 14 such amount is received, to the extent that such payment is
 15 attributable—

16 (1) to the increase in monthly insurance benefits
 17 under the old-age, survivors, and disability insurance
 18 system resulting from the enactment of section 301 of
 19 this Act, or

20 (2) to the payment of child’s insurance benefits
 21 under such system after attainment of age 18, in the
 22 case of individuals attending school, resulting from the
 23 enactment of section 306 of this Act.

1 EXTENSION OF GRACE PERIOD FOR DISREGARDING CERTAIN
 2 INCOME FOR STATES WHERE LEGISLATURE HAS NOT
 3 MET IN REGULAR SESSION

4 SEC. 407. Notwithstanding the provisions of section
 5 701 of the Economic Opportunity Act of 1964, no funds to
 6 which a State is otherwise entitled under title I, IV, X,
 7 XIV, XVI, or XIX of the Social Security Act for any pe-
 8 riod before the first month beginning after the adjournment
 9 of a State's first regular legislative session which adjourns
 10 after August 20, 1964 (the date of enactment of the Eco-
 11 nomic Opportunity Act of 1964), shall be withheld by reason
 12 of any action taken pursuant to a State statute which prevents
 13 such State from complying with the requirements of subsec-
 14 tion (a) of such section 701.

15 TECHNICAL AMENDMENTS TO ELIMINATE PUBLIC ASSIST-
 16 ANCE PROVISIONS WHICH BECOME OBSOLETE IN 1967

17 SEC. 408. (a) Except as provided in subsection (i) (2),
 18 the amendments made by this section shall become effective
 19 July 1, 1967.

20 (b) (1) The heading of title I of the Social Security
 21 Act is amended by striking out "AND MEDICAL AS-
 22 SISTANCE FOR THE AGED".

23 (2) The first sentence of section 1 of such Act is
 24 amended to read as follows: "For the purpose (a) of ena-
 25 bling each State, as far as practicable under the conditions in
 26 such State, to furnish financial assistance to aged needy indi-

viduals, and (b) of encouraging each State, as far as practicable under the conditions in such State, to furnish rehabilitation and other services to help such individuals to attain or retain capability for self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title.”

(3) The second sentence of section 1 of such Act is amended by striking out “, or for medical assistance for the aged, or for old-age assistance and medical assistance for the aged”.

(4) The heading of section 2 of such Act is amended by striking out “AND MEDICAL”.

(5) So much of section 2 (a) of such Act as precedes paragraph (1) is amended by striking out “, or for medical assistance for the aged, or for old-age assistance and medical assistance for the aged”.

(6) Section 2 (a) (9) of such Act is amended by striking out “assistance for or on behalf of” and inserting in lieu thereof “assistance to”.

(7) Section 2 (a) of such Act is further amended by striking out paragraphs (10) and (11) and inserting in lieu thereof the following:

“(10) provide that the State agency shall, in determining need, take into consideration any other income and resources of an individual claiming such assistance, as well as any expenses reasonably attributable to

1 the earning of any such income; except that, in mak-
 2 ing such determination, of the first \$80 per month of
 3 earned income the State agency may disregard not more
 4 than the first \$20 thereof plus one-half of the remainder;

5 “(11) include reasonable standards, consistent with
 6 the objectives of this title, for determining eligibility
 7 for and the extent of assistance under the plan;

8 “(12) provide a description of the services (if any)
 9 which the State agency makes available to applicants
 10 for and recipients of assistance under the plan to help
 11 them attain self-care, including a description of the steps
 12 taken to assure, in the provision of such services, maxi-
 13 mum utilization of other agencies providing similar or
 14 related services;”.

15 (8) Section 2 (a) of such Act is further amended by
 16 redesignating paragraphs (12) and (13) as paragraphs
 17 (13) and (14), respectively; and—

18 (A) the paragraph so redesignated as paragraph
 19 (13) is amended—

20 (i) by striking out “or in behalf of” in the
 21 matter preceding clause (A), and

22 (ii) by striking out “section 3 (a) (4) (A)
 23 (i) and (ii)” in clause (C) and inserting in lieu
 24 thereof “section 3 (a) (3) (A) (i) and (ii)”; and

25 (B) the paragraph so redesignated as paragraph
 26 (14) is amended by striking out “or in behalf of”.

1 (9) Section 2 (b) (2) of such Act is amended by strik-
2 ing out “(A) in the case of applicants for old-age assist-
3 ance”, and by striking out “, and (B) in the case of appli-
4 cants for medical assistance for the aged, excludes any indi-
5 vidual who resides in the State”.

6 (10) Section 2 (c) of such Act is repealed.

7 (11) So much of section 3 (a) (1) of such Act as pre-
8 cedes clause (A) is amended by striking out “during each
9 month of such quarter” and inserting in lieu thereof “dur-
10 ing such quarter”, and by striking out “(including expendi-
11 tures for premiums under part B of title XVIII for in-
12 dividuals who are recipients of money payments under such
13 plan and other insurance premiums for medical or any other
14 type of remedial care or the cost thereof) ”.

15 (12) Section 3 (a) (1) (A) of such Act is amended
16 by striking out “such month” where it first appears and
17 inserting in lieu thereof “any month”, and by striking out
18 “(which total number” and all that follows and inserting
19 in lieu thereof “; plus”.

20 (13) Section 3 (a) (1) (B) of such Act is amended to
21 read as follows:

22 “(B) the Federal percentage (as defined in
23 section 1101 (a) (8)) of the amount by which such
24 expenditures exceed the maximum which may be
25 counted under clause (A), not counting so much
26 of any expenditure with respect to any month as

1 exceeds the product of \$75 multiplied by the total
2 number of such recipients of old-age assistance for
3 such month;”.

4 (14) Section 3 (a) (2) of such Act is amended to read
5 as follows:

6 “(2) in the case of Puerto Rico, the Virgin Islands,
7 and Guam, an amount equal to one-half of the total of
8 the sums expended during such quarter as old-age assist-
9 ance under the State plan, not counting so much of any
10 expenditure with respect to any month as exceeds \$37.50
11 multiplied by the total number of recipients of old-age
12 assistance for such month;”.

13 (15) Section 3 (a) (3) of such Act is repealed.

14 (16) Section 3 (a) (4) of such Act is redesignated as
15 section 3 (a) (3).

16 (17) Section 3 (a) (5) of such Act is redesignated as
17 section 3 (a) (4), and as so redesignated is amended by
18 striking out “paragraph (4)” and inserting in lieu thereof
19 “paragraph (3)”.

20 (18) Section 3 (c) of such Act is amended by striking
21 out “paragraph (4)” each place it appears and inserting in
22 lieu thereof “paragraph (3)”, and by striking out “para-
23 graph (5)” and inserting in lieu thereof “paragraph (4)”.

24 (19) The heading of section 6 of such Act is amended by
25 striking out “Definitions” and inserting in lieu thereof
26 “Definition”.

1 (20) The first sentence of section 6 (a) of such Act
2 (as amended by this Act) is amended—

3 (A) by striking out “(a)”,

4 (B) by striking out “, or (if provided in or after
5 the third month before the month in which the recipient
6 makes application for assistance) medical care in behalf
7 of or any type of remedial care recognized under State
8 law in behalf of,” and

9 (C) by striking out “or care in behalf of”.

10 (21) Sections 6 (b) and 6 (c) of such Act are repealed.

11 (c) (1) So much of section 403 (a) (1) of such Act as
12 precedes clause (A) is amended by striking out “(including
13 expenditures for premiums under part B of title XVIII for
14 individuals who are recipients of money payments under
15 such plan and other insurance premiums for medical or any
16 other type of remedial care or the cost thereof)”.

17 (2) Section 403 (a) (1) (A) of such act is amended by
18 striking out clauses (i), (ii), and (iii) and inserting in lieu
19 thereof the following: “(i) the number of individuals with
20 respect to whom such aid is paid for such month plus (ii)
21 the number of other individuals with respect to whom pay-
22 ments described in section 406 (b) (2) are made in such
23 month and included as expenditures for purposes of this para-
24 graph or paragraph (2))”.

25 (3) Section 403 (a) (2) of such Act is amended by
26 striking out “(including expenditures for insurance premiums

1 for medical or any other type of remedial care or the cost
2 thereof) ”.

3 (4) So much of section 406 (b) of such Act as precedes
4 “to meet the needs of the relative” where it first appears is
5 amended to read as follows:

6 “(b) The term ‘aid to families with dependent children’
7 means money payments with respect to a dependent child
8 or dependent children, and includes (1) money pay-
9 ments”.

10 (5) Section 409 (a) of such Act is amended by striking
11 out “(other than for medical or any other type of remedial
12 care) ”.

13 (d) (1) So much of section 1003 (a) (1) as precedes
14 clause (A) is amended by striking out “(including expendi-
15 tures for premiums under part B of title XVIII for indi-
16 viduals who are recipients of money payments under such
17 plan and other insurance premiums for medical or any other
18 type of remedial care or the cost thereof) ”.

19 (2) Section 1003 (a) (1) (A) of such Act is amended
20 by striking out “(which total number” and all that follows
21 and inserting in lieu thereof “; plus”.

22 (3) Section 1003 (a) (2) of such Act is amended by
23 striking out “(including expenditures for insurance premiums
24 for medical or any other type of remedial care or the cost
25 thereof) ”.

26 (4) Section 1006 of such Act is amended—

27 (A) by striking out “, or (if provided in or after

1 the third month before the month in which the recipient
 2 makes application for aid) medical care in behalf of or
 3 any type of remedial care recognized under State law in
 4 behalf of,” and

5 (B) by striking out “or care in behalf of”.

6 (e) (1) So much of section 1403 (a) (1) of such Act
 7 as precedes clause (A) is amended by striking out “(includ-
 8 ing expenditures for premiums under part B of title XVIII
 9 for individuals who are recipients of money payments under
 10 such plan and other insurance premiums for medical or any
 11 other type of remedial care or the cost thereof)”.

12 (2) Section 1403 (a) (1) (A) of such Act is amended
 13 by striking out “(which total number” and all that follows
 14 and inserting in lieu thereof “; plus”.

15 (3) Section 1403 (a) (2) of such Act is amended by
 16 striking out “(including expenditures for insurance pre-
 17 miums for medical or any other type of remedial care or
 18 the cost thereof)”.

19 (4) Section 1405 of such Act is amended—

20 (A) by striking out “, or (if provided in or after
 21 the third month before the month in which the recipient
 22 makes application for aid) medical care in behalf of,
 23 or any type of remedial care recognized under State law
 24 in behalf of,” and

25 (B) by striking out “or care in behalf of”.

1 (f) (1) The heading for title XVI of such Act is
2 amended by striking out “, OR FOR SUCH AID AND
3 MEDICAL ASSISTANCE FOR THE AGED”.

4 (2) The first sentence of section 1601 of such Act is
5 amended to read as follows: “For the purpose (a) of en-
6 abling each State, as far as practicable under the conditions
7 in such State, to furnish financial assistance to needy indi-
8 viduals who are 65 years of age or over, are blind, or are 18
9 years of age or over and permanently and totally disabled,
10 and (b) of encouraging each State, as far as practicable
11 under the conditions in such State, to furnish rehabilitation
12 and other services to help such individuals to attain or retain
13 capability for self-support or self-care, there is hereby au-
14 thorized to be appropriated for each fiscal year a sum suffi-
15 cient to carry out the purposes of this title.”

16 (3) The second sentence of section 1601 of such Act is
17 amended by striking out “, or for aid to the aged, blind, or
18 disabled and medical assistance for the aged”.

19 (4) The heading for section 1602 of such Act is
20 amended by striking out “, OR FOR SUCH AID AND MEDICAL
21 ASSISTANCE FOR THE AGED”.

22 (5) So much of section 1602 (a) of such Act as pre-
23 cedes paragraph (1) is amended by striking out “, or for
24 aid to the aged, blind, or disabled and medical assistance for
25 the aged,”.

26 (6) Section 1602 (a) of such Act is further amended by

1 striking out “or assistance” wherever it appears in para-
2 graphs (4), (8), (10), (11), and (13).

3 (7) Section 1602 (a) (9) of such Act is amended by
4 striking out “aid or assistance to or on behalf of” and insert-
5 ing in lieu thereof “aid to”.

6 (8) Section 1602 (a) of such Act is further amended
7 by striking out paragraph (15), and by redesignating para-
8 graphs (16) and (17) as paragraphs (15) and (16), re-
9 spectively; and—

10 (A) the paragraph so redesignated as paragraph
11 (15) is amended—

12 (i) by striking out “or in behalf of” in the
13 matter preceding clause (A), and

14 (ii) by striking out “section 1603 (a) (4) (A)
15 (i) and (ii)” in clause (C) and inserting in lieu
16 thereof “section 1603 (a) (3) (A) (i) and (ii)”;
17 and

18 (B) the paragraph so redesignated as paragraph
19 (16) is amended by striking out “or in behalf of”.

20 (9) The last sentence of section 1602 (a) of such Act
21 is amended by striking out “(or for aid to the aged, blind, or
22 disabled and medical assistance for the aged)”.

23 (10) Section 1602 (b) of such Act is amended—

24 (A) by striking out “or assistance”,

25 (B) by striking out “(A) in the case of applicants
26 for aid to the aged, blind, or disabled”, and

1 (C) by striking out “, and (B) in the case of ap-
2 plicants for medical assistance for the aged, excludes any
3 individual who resides in the State”.

4 (11) The last sentence of section 1602 (b) of such Act
5 is amended by striking out “(or for aid to the aged, blind,
6 or disabled and medical assistance for the aged)” wherever
7 it appears.

8 (12) Section 1602 (c) of such Act is repealed.

9 (13) So much of section 1603 (a) (1) as precedes clause
10 (A) is amended by striking out “during each month of such
11 quarter” and inserting in lieu thereof “during such quarter”,
12 and by striking out “(including expenditures for premiums
13 under part B of title XVIII for individuals who are recipi-
14 ents of money payments under such plan and other insurance
15 premiums for medical or any other type of remedial care or
16 the cost thereof)”.

17 (14) Section 1603 (a) (1) (A) of such Act is amended
18 by striking out “such month” where it first appears and
19 inserting in lieu thereof “any month”, and by striking out
20 “(which total number” and all that follows and inserting in
21 lieu thereof “; plus”.

22 (15) Section 1603 (a) (1) (B) of such Act is amended
23 to read as follows:

24 “(B) the Federal percentage (as defined in sec-
25 tion 1101 (a) (8)) of the amount by which such
26 expenditures exceed the maximum which may be

1 counted under clause (A), not counting so much of
2 any expenditure with respect to any month as ex-
3 ceeds the product of \$75 multiplied by the total
4 number of recipients of aid to the aged, blind, or dis-
5 abled for such month;”.

6 (16) Section 1603 (a) (2) of such Act is amended to
7 read as follows:

8 “(2) in the case of Puerto Rico, the Virgin Islands,
9 and Guam, an amount equal to one-half of the total of the
10 sums expended during such quarter as aid to the aged,
11 blind, or disabled under the State plan, not counting so
12 much of any expenditure with respect to any month as
13 exceeds \$37.50 multiplied by the total number of recipi-
14 ents of aid to the aged, blind, or disabled for such
15 month;”.

16 (17) Section 1603 (a) (3) of such Act is repealed.

17 (18) Section 1603 (a) (4) of such Act is redesignated
18 as section 1603 (a) (3), and as so redesignated is amended
19 by striking out “or assistance” wherever it appears.

20 (19) Section 1603 (a) (5) of such Act is redesignated
21 as section 1603 (a) (4), and as so redesignated is amended
22 by striking out “paragraph (4)” and inserting in lieu thereof
23 “paragraph (3)”.

24 (20) Section 1603 (b) (3) of such Act is amended by
25 striking out “or assistance” wherever it appears.

26 (21) Section 1603 (c) of such Act is amended by strik-

1 ing out “paragraph (4)” wherever it appears and inserting
 2 in lieu thereof “paragraph (3)”, and by striking out “para-
 3 graph (5)” and inserting in lieu thereof “paragraph (4)”.

4 (22) The first sentence of section 1605 (a) of such Act
 5 (as amended by this Act) is amended—

6 (A) by striking out “(a)”,

7 (B) by striking out “, or (if provided in or after
 8 the third month before the month in which the re-
 9 cipient makes application for aid) medical care in be-
 10 half of or any type of remedial care recognized under
 11 State law in behalf of,” and

12 (C) by striking out “or care in behalf of” each
 13 place it appears.

14 (23) Section 1605 (b) of such Act is repealed.

15 (g) (1) Section 1902 (a) (20) (C) of such Act is
 16 amended by striking out “section 3 (a) (4) (A) (i) and (ii)
 17 or section 1603 (a) (4) (A) (i) and (ii)” and inserting in
 18 lieu thereof “section 3 (a) (3) (A) (i) and (ii) or section
 19 1603 (a) (3) (A) (i) and (ii)”.

20 (2) Section 1903 (a) (3) (A) (i) of such Act is
 21 amended by striking out “section 3 (a) (4)” and inserting
 22 in lieu thereof “section 3 (a) (3)”.

23 (h) Section 618 of the Revenue Act of 1951 is amended
 24 by striking out “(other than section 3 (a) (3) thereof)” and
 25 “(other than section 1603 (a) (3) thereof)”.

26 (i) (1) Section 1108 of such Act is amended—

1 (A) by striking out “(other than section 3 (a) (3)
2 thereof)” and “(other than section 1603 (a) (3) there-
3 of)”;

4 (B) by striking out “\$9,800,000, of which
5 \$625,000 may be used only for payments certified with
6 respect to section 3 (a) (2) (B) or 1603 (a) (2) (B)”
7 and inserting in lieu thereof “\$9,800,000”;

8 (C) by striking out “\$330,000, of which \$18,750
9 may be used only for payments certified with respect to
10 section 3 (a) (2) (B) or 1603 (a) (2) (B)” and insert-
11 ing in lieu thereof “\$330,000”; and

12 (D) by striking out “\$450,000, of which \$25,000
13 may be used only for payments certified with respect to
14 section 3 (a) (2) (B) or 1603 (a) (2) (B)” and insert-
15 ing in lieu thereof “\$450,000”.

16 (2) The amendments made by paragraphs (1) (B),
17 (1) (C), and (1) (D) shall be effective in the case of Puerto
18 Rico, the Virgin Islands, or Guam with respect to fiscal years
19 beginning on or after the date on which its plan under title
20 XIX of the Social Security Act is approved, or beginning on
21 or after July 1, 1967, whichever is earlier.

22 (j) Section 1109 of such Act is amended by striking out
23 “2 (a) (10) (A)” and inserting in lieu thereof “2 (a) (10)”.

24 (k) (1) Section 1112 of such Act is amended by strik-
25 ing out “for the aged”.

1 (2) The heading of section 1112 of such Act is amended
2 by striking out "FOR THE AGED".

3 (1) Section 1115 of such Act is amended by striking
4 out "or XVI", "or 1602", and "or 1603" and inserting in
5 lieu thereof "XVI, or XIX", "1602, or 1902", and "1603,
6 or 1903", respectively.

Union Calendar No. 95

89TH CONGRESS
1ST SESSION

H. R. 6675

[Report No. 213]

A BILL

To provide a hospital insurance program for the aged under the Social Security Act with a supplementary health benefits program and an expanded program of medical assistance, to increase benefits under the Old-Age, Survivors, and Disability Insurance System, to improve the Federal-State public assistance programs, and for other purposes.

By Mr. Mills

MARCH 24, 1965

Referred to the Committee on Ways and Means

MARCH 29, 1965

Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

[COMMITTEE PRINT]

SUMMARY OF MAJOR PROVISIONS
OF
H.R. 6675
THE "SOCIAL SECURITY AMENDMENTS OF 1965"
As Reported
TO THE
HOUSE OF REPRESENTATIVES
BY THE
COMMITTEE ON WAYS AND MEANS
ON
MARCH 29, 1965

TO PROVIDE A HOSPITAL INSURANCE PROGRAM FOR THE
AGED UNDER THE SOCIAL SECURITY ACT WITH A SUP-
PLEMENTARY HEALTH BENEFITS PROGRAM AND AN
EXPANDED PROGRAM OF MEDICAL ASSISTANCE, TO IN-
CREASE BENEFITS UNDER THE OLD-AGE, SURVIVORS,
AND DISABILITY INSURANCE SYSTEM, TO IMPROVE THE
FEDERAL-STATE PUBLIC ASSISTANCE PROGRAMS, AND
FOR OTHER PURPOSES



NOTE: The report of the Committee on Ways and Means on this
bill is House Report No. 213

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BRIEF OVERALL SUMMARY

The bill establishes two coordinated health insurance programs for persons 65 or over under the Social Security Act: (1) a "basic" plan providing protection against the costs of hospital and related care, financed through a separate payroll tax and trust fund; and (2) a voluntary "supplementary" plan covering payments for physicians' and other medical and health services financed through small monthly premiums by individual participants matched equally by a Federal Government general revenue contribution.

Undergirding the two new insurance programs would be a greatly expanded medical care program for the needy and the medically needy. This program would combine all the vendor medical provisions for the aged, blind, disabled, and families with dependent children now in five titles of the Social Security Act under a uniform program and matching formula in a single new title. The Federal matching share for cash payments for these needy persons would also be increased; services for maternal and child health, crippled children, and the mentally retarded would be expanded; a 5-year program of "special project grants" to provide comprehensive health care and services for needy children of school age, or preschool, would be authorized; and present limitations on Federal participation in public assistance to aged individuals in tuberculosis or mental disease hospitals would be removed under certain conditions.

With respect to the old-age, survivors, and disability insurance system the bill would increase benefits by 7 percent across the board with a \$4 minimum increase for a worker, cover certain currently uncovered occupations and wages (doctors, and income from tips), continue benefits to age 22 for certain children in school, provide social security tax exemption of self-employment income of certain religious groups opposed to insurance, provide actuarially reduced benefits for widows at age 60, and pay benefits, on a transitional basis, to certain persons currently 72 or over now ineligible; liberalize the definition for disability insurance benefits, increase the amount an individual is permitted to earn without suffering full deductions from benefits, revise the tax schedule, and increase the earnings counted for benefit and tax purposes so as to fully finance the changes made, and make certain changes in allocations to the old-age and survivors insurance and disability insurance trust funds.

MORE DETAILED SUMMARY

I. HEALTH INSURANCE FOR THE AGED

The bill would add a new title XVIII to the Social Security Act establishing two related health insurance programs for persons 65 or over: (1) a basic plan providing protection against the costs of hospital and related care; and (2) a voluntary supplementary plan covering payments for physicians' services and other medical and health services to cover certain areas not covered by the basic plan.

The basic plan would be financed through a separate payroll tax and separate trust fund. Benefits for persons currently over 65 who are not insured under the social security and railroad retirement systems would be financed out of Federal general revenues.

Enrollment in the supplementary plan would be voluntary and would be financed by a small monthly premium (\$3 per month initially) paid by enrollees and an equal amount supplied by the Federal Government out of general revenues. The premiums for social security and railroad retirement beneficiaries who voluntarily enroll would be deducted from their monthly insurance benefits. Uninsured persons desiring the supplemental plan would make the periodic premium payments to the Government. State welfare programs could arrange for uninsured assistance recipients to be covered.

A. BASIC PLAN

General description.—Basic protection, financed through a separately identified payroll tax, would be provided against the costs of inpatient hospital services, posthospital extended care, posthospital home health services, and outpatient hospital diagnostic services for social security and railroad retirement beneficiaries when they attain age 65. The same protection, financed from general revenues, would be provided under a special transitional provision for essentially all people who are now aged 65, or who will reach age 65 before 1968, but who are not eligible for social security or railroad retirement benefits.

Benefits would be first effective on July 1, 1966, except for services in extended care facilities which would be effective on January 1, 1967.

Benefits.—The services for which payment would be made under the basic plan include—

(1) inpatient hospital services for up to 60 days in each spell of illness with the patient paying a \$40 deductible amount; hospital services would include all those ordinarily furnished by a hospital for its inpatients; however, payment would not be made for private duty nursing or for the hospital services of physicians except services provided by interns or residents in training under approved teaching programs;

(2) posthospital extended care (in a facility having an arrangement with a hospital for the timely transfer of patients and for furnishing medical information about patients) after the patient

is transferred from a hospital (after at least a 3-day stay) for up to 20 days in each spell of illness; 2 additional days will be added to the 20 days for each day that the person's hospital stay was less than 60 days (up to a maximum of 80 additional days)—the overall maximum for posthospital extended care could thus be 100 days in each spell of illness;

(3) outpatient hospital diagnostic services with the patient paying a \$20 deductible amount for each diagnostic study (that is, for diagnostic services furnished to him by the same hospital during a 20-day period); if, within 20 days after receiving such services, the individual is hospitalized as an inpatient in the same hospital, the deductible he paid for outpatient diagnostic services (up to \$20) would be credited against the inpatient hospital deductible (\$40); and

(4) posthospital home health services for up to 100 visits, after discharge from a hospital (after at least a 3-day stay) or extended care facility and before the beginning of a new spell of illness. Such a person must be in the care of a physician and under a plan established by a physician within 14 days of discharge calling for such services. These services would include intermittent nursing care, therapy, and the part-time services of a home health aide. The patient must be homebound, except that when equipment is used the individual could be taken to a hospital or extended care facility or rehabilitation center to receive some of these covered home health services in order to get advantage of the necessary equipment.

No service would be covered as posthospital extended care or as outpatient diagnostic or posthospital home health services if it is of a kind that could not be covered if it were furnished to a patient in a hospital.

A spell of illness would be considered to begin when the individual enters a hospital and to end when he has not been an inpatient of a hospital or extended care facility for 60 consecutive days.

The deductible amounts for inpatient hospital and outpatient hospital diagnostic services would be increased if necessary to keep pace with increases in hospital costs, but no such increase would be made before 1969. For reasons of administrative simplicity, increases in the hospital deductible will be made only when a \$5 change is called for and the outpatient deductible will change in \$2.50 steps.

Basis of reimbursement.—Payment of bills under the basic plan would be made to the providers of service on the basis of the "reasonable cost" incurred in providing care for beneficiaries.

Administration.—Basic responsibility for administration would rest with the Secretary of Health, Education, and Welfare. The Secretary would use appropriate State agencies and private organizations (nominated by providers of services) to assist in the administration of the program. Provision is made for the establishment of an Advisory Council which would advise the Secretary on policy matters in connection with administration.

Financing.—Separate payroll taxes to finance the basic plan, paid by employers, employees, and self-employed persons, would be earmarked in a separate hospital insurance trust fund established in the Treasury. The amount of earnings (wage base) subject to the new payroll taxes would be the same as for purposes of financing social

security cash benefits. The same contribution rate would apply equally to employers, employees, and self-employed persons and would be as follows:

	<i>Percent</i>
1966-----	0.35
1967-72-----	.50
1973-75-----	.55
1976-79-----	.60
1980-86-----	.70
1987 and thereafter-----	.80

The taxable earnings base for the health insurance tax would be \$5,600 a year for 1966 through 1970 and would thereafter be increased to \$6,600 a year.

The schedule of contribution rates is based on estimates of cost which assume that the earnings base will not be increased above \$6,600. If Congress, in later years, should increase the base above \$6,600, the tax rates established can be reduced under the cost assumptions underlying the bill.

The cost of providing basic hospital and related benefits to people who are not social security or railroad retirement beneficiaries would be paid from general funds of the Treasury.

B. VOLUNTARY SUPPLEMENTARY PLAN

General description.—A package of benefits supplementing those provided under the basic plan would be offered to all persons 65 and over on a voluntary basis. Individuals who enroll initially would pay premiums of \$3 a month (deducted, where possible, from social security or railroad retirement benefits). The government would match this premium with \$3 paid from general funds. Since the minimum increase in cash social security benefits for retired workers under the bill would be \$4 a month (\$6 a month for man and wife receiving benefits based on the same earnings record), the benefit increases would fully cover the amount of monthly premiums.

Enrollment.—Persons aged 65 before January 1, 1966, will have an opportunity to enroll in an enrollment period which begins on the first day of the second month after the month of enactment and ends March 31, 1966.

Persons attaining age 65 subsequent to December 31, 1965, will have enrollment periods of 7 months beginning 3 months before attaining 65.

In the future general enrollment periods will be from October to December 31, in each odd year. The first such period will be October 1 to December 31, 1967.

No person may enroll more than 3 years after close of first enrollment period in which he could have enrolled.

There will be only one chance to reenroll for persons who are in the plan but drop out, and reenrollment must occur within 3 years of termination of previous enrollment.

Coverage may be terminated (1) by the individual filing notice during enrollment period, or (2) by the Government, for nonpayment of premiums.

A State would be able to provide the supplementary insurance benefits to its public assistance recipients who are receiving cash assistance if it chooses to do so.

Benefits will be effective beginning July 1, 1966.

Benefits.—The voluntary supplementary insurance plan would cover physicians' services, home health services, hospital services in psychiatric institutions, and numerous other medical and health services in and out of medical institutions.

There would be an annual deductible of \$50. Then the plan would cover 80 percent of the patient's bill (above the deductible) of the following services:

(1) Physicians' and surgeons' services, whether furnished in a hospital, clinic, office, in the home, or elsewhere;

(2) Hospital care for 60 days in a spell of illness in a mental hospital (180-day lifetime maximum);

(3) Home health services (with no requirement of prior hospitalization) for up to 100 visits during each calendar year;

(4) Additional medical and health services, whether provided in or out of a medical institution, including the following:

(a) Diagnostic X-ray and laboratory tests, electrocardiograms, basal metabolism readings, electroencephalograms, and other diagnostic tests;

(b) X-ray, radium, and radioactive isotope therapy;

(c) Ambulance services (under limited conditions); and

(d) Surgical dressings and splints, casts, and other devices for reduction of fractures and dislocations; rental of durable medical equipment such as iron lungs, oxygen tents, hospital beds, and wheelchairs used in the patient's home; prosthetic devices (other than dental) which replace all or part of an internal body organ; braces and artificial legs, arms, eyes, etc.

There would be a special limitation on outside-the-hospital treatment of mental, psychoneurotic, and personality disorders. Payment for such treatment during any calendar year would be limited, in effect, to \$250 or 50 percent of the expenses, whichever is smaller.

Administration by carriers: Basis for reimbursement.—The Secretary of Health, Education, and Welfare would be required, to the extent possible, contract with carriers to carry out the major administrative functions relating to the medical aspects of the program such as determining rates of payments under the program, holding and disbursing funds for benefit payments, and determining compliance and assisting in utilization review. No contract is to be entered into by the Secretary unless he finds that the carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent. The contract must provide that the carrier take necessary action to see that where payments are on a cost basis (to institutional providers of service), the cost is reasonable cost. Correspondingly, where payments are on a charge basis (to physicians or others furnishing noninstitutional services), the carrier must see that such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the other policyholders and subscribers of the carrier. Payment by the carrier for physicians' services will be made on the basis of a receipted bill, or on the basis of an assignment under the terms of which the reasonable charge will be the full charge for the service.

Financing.—Aged persons who enroll in the supplemental plan would pay monthly premiums of \$3. Where the individual is

currently receiving monthly social security or railroad retirement benefits, the premiums would be deducted from his benefits.

The Government would help finance the supplementary plan through a payment from general revenues of \$3 a month per enrollee. To provide an operating fund at the beginning of the supplementary plan, and to establish a contingency reserve, a Government appropriation would be available (on a repayable basis) equal to \$18 per aged person estimated to be eligible in July 1966 when the supplementary plan goes into effect.

The individual and Government contributions would be placed in a separate trust fund for the supplementary plan. All benefit and administrative expenses under the supplementary plan would be paid from this fund.

The provision in the income tax law which limits medical expense deductions to amounts in excess of 3 percent of adjusted gross income for persons under 65 would be reinstituted for persons 65 and over. Thus, provision is made for partial or full recovery of the Government contribution from enrolled persons with incomes high enough to require them to pay income taxes. A special deduction (for taxpayers who itemize deductions) of one-half of premiums for medical care insurance would be added, however, which would be applicable to taxpayers of all ages. Such special deduction could not exceed \$250 per year.

Premium rates for enrolled persons (and the matching Government contribution) would be increased from time to time in the event that costs rise, but not more often than once every 2 years. The premium rate for a person who enrolls after the first period when enrollment was open to him would be increased by 10 percent for each full year he stayed out of the program. It would also be increased for any period that he had terminated his coverage.

C. COSTS OF THE BASIC AND SUPPLEMENTARY PLANS

Benefits under both plans would first become payable for services furnished in July 1966, except for services in extended care facilities, for which benefits would first become payable in January 1967.

Basic plan.—Benefits under the basic plan would be about \$1.0 billion for the 6-month period in 1966 and about \$2.2 billion in 1967. Contribution income for those years would be about \$1.6 and \$2.6 billion, respectively. The costs for the uninsured (paid from general funds) would be about \$275 million per year for early years.

Supplementary plan.—Costs of the supplementary plan would depend on how many of the aged enrolled.

If 80 percent of the eligible aged enrolled, benefit costs of the supplementary plan would be about \$195 million to \$260 million in the 6 months of 1966 and about \$765 million to \$1.02 billion in 1967. Premium income from enrollees for those years would be about \$275 and \$560 million, respectively. The matching Government contribution would be the same.

If 95 percent of the eligible aged enrolled, benefit costs of the supplementary plan would be about \$230 to \$310 million in 1966 and about \$905 million to \$1.22 billion in 1967. Premium income from enrollees for those years would be about \$325 and \$665 million, respectively. The Government contribution would be the same.

II. IMPROVEMENT AND EXTENSION OF KERR-MILLS PROGRAM

Purpose and scope.—In order to provide a more effective Kerr-Mills program and to extend its provisions to other needy persons, the bill would establish a single and separate medical care program to replace the differing provisions for the needy which currently are found in five titles of the Social Security Act.

The new title (XIX) would extend the advantages of an expanded medical assistance program not only to the aged who are indigent but also to needy individuals on the dependent children, blind, and permanently and totally disabled programs and to persons who would qualify under those programs if in sufficient financial need.

Inclusion of the medically indigent aged would be optional with the States but if they are included comparable groups of blind, disabled, and parents and children must also be included if they need help in meeting necessary medical costs. Moreover, the amount and scope of benefits for the medically indigent could not be greater than that of recipients on the cash assistance programs.

The current provisions of law in the various public assistance titles of the act providing vendor medical assistance would terminate upon the adoption of the new program by a State but no later than June 30, 1967.

Scope of medical assistance.—Under existing law, the State must provide "some institutional and noninstitutional care" under the medical assistance for the aged program. There are no minimum benefit requirements at all under the other public assistance vendor medical programs. The bill would require that by July 1, 1967, for the new program a State must provide inpatient hospital services, outpatient hospital services, other laboratory and X-ray services, skilled nursing home services, and physicians services (whether furnished in the office, the patient's home, a hospital, or a skilled nursing home) in order to receive Federal participation in vendor medical payments. Other items of medical service would be optional with the States.

Eligibility.—Improvements would be effectuated in the program for the needy elderly by requiring that the States must provide a flexible income test which takes into account medical expenses and does not provide rigid income standards which arbitrarily deny assistance to people with large medical bills. In the same spirit the bill provides that no deductible, cost sharing, or similar charge may be imposed by the State as to hospitalization under its program and that any such charge on other medical services must be reasonably related to the recipient's income or resources. Also important is the requirement that elderly needy people on the State programs be provided assistance to meet the deductibles that are imposed by the new basic program of hospital insurance. Also where a portion of any deductible or cost sharing required by the supplementary voluntary program is met by a State program it must be done so in a manner reasonably related to the individual's income and resources. No income can be imputed to an individual unless actually available; and the financial responsibility of an individual for an applicant may be taken into account only if the applicant is the individual's spouse or child who is under age 21 or blind or disabled.

Increased Federal matching.—The Federal share of medical assistance expenditures under the new program would be determined upon a uniform formula with no maximum on the amount of expenditures which would be subject to participation. This currently is done for the medical assistance for the aged program. The Federal share, which varies in relation to a State's per capita income, would be increased over current medical assistance for the aged matching so that States at the national average would receive 55 percent rather than 50 percent, and States at the lowest level could receive as much as 83 percent as contrasted with 80 percent under existing law.

In order to receive any additional Federal funds as a result of expenditures under the new program, the States would need to continue their own expenditures at their present rate. For a specified period, no State would receive less in Federal funds than under current provisions of law because of the new formula and any State that did not reduce its own expenditures would be assured of a 5-percent increase in Federal participation in medical care expenditures. As to professional medical personnel, the bill would provide a 75-percent Federal share as compared with the 50-50 Federal-State sharing for other administrative expenses.

Administration.—The State agency administering the new program would have to be the same as that administering the old-age assistance program. As some States have done under existing law, such an agency could delegate its function relating to the medical aspects of the program to the State health agency. The bill specifically provides as a State plan requirement that cooperative agreements be entered into with State agencies providing health services and vocational rehabilitation services looking toward maximum utilization of these services in the provision of medical assistance under the plan.

Effective date.—January 1, 1966.

Cost.—It is estimated that the new program will increase the Federal Government's contribution about \$200 million in a full year of operation over that in the programs operated under existing law.

III. CHILD HEALTH PROGRAM AMENDMENTS

Maternal and child health and crippled children.—The bill would increase the amount authorized for maternal and child health services over current authorizations by \$5 million for fiscal year 1966 and by \$10 million in each succeeding fiscal year, as follows:

Fiscal year	Existing law	Under bill
1966.....	\$40,000,000	\$45,000,000
1967.....	40,000,000	50,000,000
1968.....	45,000,000	55,000,000
1969.....	45,000,000	55,000,000
1970 and after.....	50,000,000	60,000,000

The authorizations for crippled children's service would be increased by the same amounts. Such increases would assist the States, in both these programs, in moving toward the goal of extending services with a view of making them available to children in all parts of the State by July 1, 1975.

Crippled children-training personnel.—The bill would also authorize \$5 million for the fiscal year 1967, \$10 million for fiscal 1968, and

\$17.5 million for each succeeding fiscal year to be for grants to institutions of higher learning for training professional personnel for health and related care of crippled children, particularly mentally retarded children with multiple handicaps.

Health care for needy children.—A new provision is added authorizing the Secretary of Health, Education, and Welfare to carry out a 5-year program of special project grants to provide comprehensive health care and services for children of school age, or for preschool children, particularly in areas with concentrations of low-income families. The grants would be to State health agencies, to the State agencies administering the crippled children's program, to any school of medicine (with appropriate participation by a school of dentistry), and any teaching hospital affiliated with such school, to pay not to exceed 75 percent of the cost of the project. Projects would provide screening, diagnosis, preventive services, treatment, correction of defects, and aftercare, including dental services, for children in low-income families.

An appropriation of \$15 million would be authorized for the fiscal year ending June 30, 1966; \$35 million for the fiscal year ending June 30, 1967; \$40 million for the fiscal year ending June 30, 1968; \$45 million for the fiscal year ending June 30, 1969; and \$50 million for the fiscal year ending June 30, 1970.

Mental retardation planning.—This title would authorize grants totaling \$2,750,000 for each of 2 fiscal years—the fiscal year ending June 30, 1966, and fiscal year ending June 30, 1967. The grants would be available during the year for which the appropriation is authorized and during the succeeding fiscal year. They are for the purpose of assisting States to implement and followup on plans and other steps to combat mental retardation authorized under section 1701 of the Social Security Act.

IV. OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE AMENDMENTS

BENEFITS

1. 7 percent, across-the-board benefit increase in old-age, survivors, and disability insurance benefits

The bill provides a 7-percent, across-the-board benefit increase, effective retroactively beginning with January 1965, with a minimum increase of \$4 for retired workers age 65 and older. These increases will be made for the 20 million social security beneficiaries now on the rolls.

Monthly benefits for workers who retire at or after 65 would be increased to a new minimum of \$44 (now \$40) and to a new maximum of \$135.90 (now \$127). In the future, creditable earnings under the increase in the contribution and benefit base to \$5,600 a year (now \$4,800) would make possible a maximum benefit of \$149.90.

The maximum amount of benefits payable to a family on the basis of a single earnings record would be related to the worker's average monthly earnings at all earnings levels. Under present law, there is a \$254 limit on family benefits which operates over a wide range of average monthly earnings. Under the bill, until 1971, the family maximum would be \$312.

Under the second-step increase in the wage base to \$6,600 to be effective in 1971, also provided in the bill, the worker's primary insurance amount would range from a minimum of \$44 to a future

possible maximum of \$167.90 a month. Maximum family benefits up to \$368 would also be payable.

2. Payment of child's insurance benefits to children attending school or college after attainment of age 18 and up to age 22

The bill includes the provision adopted by both House and Senate last year which would continue to pay a child's insurance benefit until the child reaches age 22, provided the child is attending public or accredited schools, including a vocational school or a college, as a full-time student after he reaches age 18. Children of deceased retired, or disabled workers would be included. No mother's or wife's benefits would be payable on the basis of a child who has attained age 18 but is in school.

This provision will be effective January 1, 1965. It is estimated that 295,000 children will be able to receive benefits for a typical school month in 1965 as a result of this provision.

3. Benefits for widows at age 60

The bill would provide the option to widows of receiving benefits beginning at age 60 with the benefits payable to those who claim them before age 62 being actuarially reduced to take account of the longer period over which they will be paid. Under present law, full widow's benefits and actuarially reduced worker's and wife's benefits are payable at age 62.

This provision, adopted by both Houses last year, would be effective for the second month after the month of enactment. It is estimated that 185,000 widows will be able to get benefits immediately under this provision.

4. Amendment of disability program

(a) *Definition.*—The bill would eliminate the present requirement that a worker's disability must be expected to result in death or to be of long-continued and indefinite duration, and instead provide that an insured worker would be eligible for disability benefits if he has been totally disabled throughout a continuous period of at least 6 calendar months. Benefits payable by reason of this change would be paid for the second month following the month of enactment.

(b) *Waiting period.*—The waiting period during which an individual must be under a disability prior to entitlement to benefits is reduced by 1 month by the bill. It provides that disability benefits would be payable beginning with the last month of the 6-month waiting period rather than with the first month after the 6-month waiting period as under existing law. This change would be applicable to all cases in which the last month of the waiting period occurs after the month of enactment.

It is estimated some 155,000 disabled workers and dependents will be benefited by these provisions.

Certain changes are also made in the provision terminating disability benefits and waiving subsequent waiting periods so as to make them more restrictive when applied to shorter term disabilities.

(c) *Entitlement to disability benefits after entitlement to benefits payable on account of age.*—Under the bill, a person who becomes entitled before age 65 to a benefit payable on account of old age could later become entitled to disability insurance benefits.

(d) *Allocation of contribution income between OASI and DI trust funds.*—Under the bill, an additional one-fourth of 1 percent of taxable

wages and three-sixteenths of 1 percent of taxable self-employment income would be allocated to the disability insurance trust fund, bringing the total allocation to three-fourths of 1 percent and nine-sixteenths of 1 percent, respectively, beginning in 1966.

5. Benefits to certain persons at age 72 or over

The bill would liberalize the eligibility requirements by providing a basic benefit of \$35 at age 72 or over to certain persons with a minimum of three quarters of coverage which can be acquired at any time since the beginning of the program in 1937. To accomplish this, a new concept of "transitional insured" status is provided. Present law requires a minimum of six quarters of coverage in employment or self-employment.

(a) *Men and women workers.*—The concept of "transitional insured" status which would make an individual eligible for an old-age or wife's benefit provides that the oldest workers will receive benefits with only three quarters of coverage, under the bill. These three quarters may have been acquired at any time since the inception of the program in 1937. For those who are not quite so old, the quarters of coverage requirement would increase until the requirement merges with the present minimum requirement of six quarters.

The following table illustrates the operation of the "transitional insured" status provision for workers:

*Workers benefits*¹

Men		Women	
Age (in 1965)	Quarters of coverage required	Age (in 1965)	Quarters of coverage required
76 or over.....	3.	73 or over.....	3.
75.....	4.	72.....	4.
74.....	5.	71.....	5.
73 or younger.....	6 or more.	70 or younger.....	6 or more.

¹ Benefits will not be payable, however, until age 72.

(b) *Widows.*—Any widow who is age 72 or over in 1966, if her husband died or reached age 65 in 1954 or earlier, can get a widow's benefit if her husband had at least three quarters of coverage. Present law requires six quarters.

If the husband died or reached 65 in 1955, the requirement is four quarters. If he died or reached 65 in 1956, the requirement would be five quarters. If he died or reached 65 in 1957 or later, the minimum requirement would be six quarters, the same as present law.

For widows reaching age 72 in 1967 and 1968, there is a "grading-in" of coverage requirement of four or five quarters of coverage, respectively. Widows reaching age 72 in 1969 or after would be subject to the requirements of existing law of six or more quarters of coverage.

The table below sets forth the requirements as to widows:

Insured status provisions with respect to widow's benefits as to quarters of coverage required

Year of husband's death (or attainment of age 65, if earlier)	Present quarters required	Proposed quarters required for widow attaining age 72 in—		
		1966 or before	1967	1968
1954 or before.....	6.....	3.....	4.....	5.
1955.....	6.....	4.....	4.....	5.
1956.....	6.....	5.....	5.....	5.
1957 or after.....	6 or more.....	6 or more.....	6 or more.....	6 or more.

(c) *Basic benefits.*—Men and women workers who would be eligible under the above-described provisions for workers would receive a basic benefit of \$35 a month. A wife, aged 72 or over (and who attains that age before 1969) would receive one-half of this amount, \$17.50. No other dependents' basic benefits would be provided under these provisions.

Widows would receive \$35 a month under the above-described provision.

These provisions would become effective for the second month after the month of enactment, at which time an estimated 355,000 persons would be able to start receiving benefits.

6. *Retirement test*

The bill liberalizes the social security earned income limitation so that the uppermost limit of the "band" of \$1 reduction in benefits for \$2 in earnings is raised from \$1,700 to \$2,400. Under existing law the first \$1,200 a year in earnings is wholly exempted, and there is a \$1 reduction in benefits for each \$2 of earnings up to \$1,700 and \$1 for \$1 above that amount. The bill would increase the \$1 for \$2 "band" so that it would apply between \$1,200 and \$2,400, with \$1 for \$1 reductions above \$2,400. This change is effective as to taxable years ending after 1965.

The bill also exempts certain royalties received in or after the year in which a person reaches age 65 from copyrights and patents obtained before age 65 from being counted as earnings for purposes of this test effective as to taxable years beginning after 1964.

7. *Wife's and widow's benefits for divorced women*

The bill would authorize payments of wife's and widow's benefits to the divorced wife aged 62 or over of a retired, deceased, or disabled worker if she had been married to the worker for at least 20 years before the date of the divorce and if her divorced husband was making (or was obligated by a court to make) a substantial contribution to her support when he became entitled to benefits, became disabled, or died. The bill would also provide that a wife's benefits would not terminate when the woman and her husband are divorced if the marriage has been in effect for 20 years. Provision is also made for the reestablishment of benefit rights for a widow or a wife who remarries and the subsequent marriage lasts less than 20 years. These changes are effective as to second month following month of enactment.

8. *Adoption of child by retired worker*

The bill would change the provisions relating to the payment of benefits to children who are adopted by old-age insurance beneficiaries to require that as to any adoption after the worker becomes entitled to an old-age benefit (1) the child be living with the worker (or adoption proceedings have begun) in or before the month when application for old-age benefits is filed; (2) the child be receiving one-half of his support for a year before the worker's entitlement; and (3) the adoption be completed within 2 years after the worker's entitlement.

COVERAGE

The following coverage provisions (contained in the House-passed bill last year) were included:

1. *Physicians and interns*

Self-employed physicians would be covered for taxable years ending after December 31, 1965. Interns would be covered beginning on January 1, 1966, on the same basis as other employees working for the same employer.

2. *Farmers*

Provisions of existing law with respect to the coverage of farmers would be amended to provide that farm operators whose annual gross earnings are \$2,400 or less (instead of \$1,800 or less as in existing law) can report either their actual net earnings or 66% percent (as in present law) of their gross earnings. Farmers whose annual gross earnings are over \$2,400 would report their actual net earnings if over \$1,600, but if actual net earnings are less than \$1,600, they may instead report \$1,600. (Present law provides that farmers whose annual gross earnings are over \$1,800 report their actual net earnings if over \$1,200, but if actual net earnings are less than \$1,200, they may report \$1,200.) This change would be effective for taxable years beginning after December 31, 1965.

3. *Cash tips*

Coverage of cash tips received by an employee in the course of his employment as wages would be provided, effective as to tips received after 1965.

(a) *Reporting of tips.*—The employee would be required to report to his employer in writing the amount of tips received and the employer would report the employee's tips along with the employee's regular wages. The employee's report to his employer would include tips paid to him through the employer as well as those received directly from customers of the employer. Tips received by an employee which do not amount to a total of \$20 a month in connection with his work for any one employer would not be covered and would not be reported.

(b) *Tax on tips.*—The employer would be required to withhold social security taxes only on tips reported by the employee to him. Unlike the provision in last year's House bill, the employer would be required to withhold income tax on such reported tips. The employer would be responsible for the social security tax on tips only if the employee reported the tips to him within 10 days after the end of the month in which the tips were received. The employer will be permitted to gear these new procedures into his usual payroll periods.

The employer would pay over his own and the employee's share of the tax on these tips and would include the tips with his regular reports of wages. If at the time the employee report is due (or, in cases where the report is made earlier—if between the making of the report and the time it is due), the employer does not have unpaid wages or remuneration of the employee under his control sufficient to cover the employee's share of the social security tax applicable to the tips reported, the employee will pay his share of the tax with his report.

If the employee does not report his tips to his employer within 10 days after the end of the month involved, the employer would have no liability. In such a case the employee alone would be liable not only for the amount of the employee tax but also an additional amount equal to the employer tax.

4. State and local government employees

Alaska and Kentucky would be added to the list of States which may cover State and local government employees under the divided retirement system provision. This provision allows current employees desiring to do so to elect coverage; future employees are covered compulsorily.

Another opportunity would be provided, through 1966, for the election of coverage by people who originally did not choose coverage under the divided retirement system provision.

Coverage would be made available to certain hospital employees in California whose positions were removed from a State or local government retirement system.

New coverage provisions in the bill (not contained in last year's bill) are:

1. *District of Columbia employees.*—Coverage would be extended to employees of the District of Columbia who are not covered by a retirement system. About 600 substitute teachers would be involved. The District of Columbia Commissioners also could shift the coverage of temporary and intermittent employees from the civil service retirement system to social security. The earliest date on which coverage could become effective would be the first day of the calendar quarter following the calendar quarter of enactment.

2. *Exemption of certain religious sects.*—Members of certain religious faiths may be exempt from social security self-employment taxes and coverage upon application which would be accompanied by a waiver of benefit rights. An individual eligible for the exemption must be a member of a recognized religious sect (or a division of a sect) who is an adherent of the established teachings of such sect by reason of which he is conscientiously opposed to acceptance of the benefits of any private or public insurance, making payments in the event of death, disability, old-age, or retirement, or making payments toward the cost of, or providing services for, medical care (including the benefits of any insurance system established by the Social Security Act). The Secretary of Health, Education, and Welfare must find that such sect has such teachings and has been in existence at all times since December 31, 1950, and that it is the practice for members of such sect to make provision for their dependent members which, in the Secretary's judgment, is reasonable in view of their general level of living. The exemption for previous years (taxable years ending prior to December 31, 1965) must be filed by April 15, 1966. The exemption would be effective as early as taxable years beginning after December 31, 1950.

3. *Nonprofit organizations.*—Nonprofit organizations could provide coverage for employees retroactively for up to 5 years (1 year under present law); also, validation of certain erroneously reported wages would be permitted.

MISCELLANEOUS

1. *Filing of proof*

Extends indefinitely the period of filing of proof of support for dependent husbands, widowers and parent's benefits, and lump-sum death payments where good cause exists for failure to file within initial 2-year period.

2. *Automatic recomputation of benefits*

The benefits of people on the rolls would be recomputed automatically each year to take account of any covered earnings that the worker might have had in the previous year that would increase his benefit amount. Under existing law there are various requirements, including filing of an application and earnings of over \$1,200 a year after entitlement.

3. *Military wage credits*

Replaces present provision authorizing reimbursement of trust funds out of general revenue for gratuitous social security wage credits for servicemen so that such payments will be spread over the next 50 years (now 10 years).

NUMBER OF PERSONS IMMEDIATELY AFFECTED AND AMOUNT OF
ADDITIONAL BENEFITS IN THE FULL YEAR 1966

7 percent benefit increase (\$4 minimum in primary benefits)---	20 million persons---	\$1.4 billion.
Child's benefit to age 22 if in school.	295,000 children----	\$195 million.
Reduced age for widows-----	185,000 widows----	\$165 million (no long-range charge to system because of actuarial reduction).
Reduction in eligibility requirement for certain persons aged 72 or over.	355,000 persons----	\$140 million.
Liberalization of disability definition.	155,000 workers, and dependents.	\$105 million.
Liberalization of retirement test---	-----	\$65 million.

FINANCING OF OASDI AMENDMENTS

The benefit provisions of the bill are financed by (1) an increase in the earnings base from \$4,800 to \$5,600 (effective January 1, 1966), and \$6,600 (effective 1971), and (2) a revised tax rate schedule.

The tax rate schedule under existing law and revised schedule provided by the bill for OASDI programs follow:

[In percent]

Years	Employer-employee rate (each)		Self-employed rate	
	Present law	Bill	Present law	Bill
1965.....	3.625	3.625	5.4	5.4
1966.....	4.125	4.0	6.2	6.0
1967.....	4.125	4.0	6.2	6.0
1968.....	4.625	4.0	6.9	6.0
1969-72.....	4.625	4.4	6.9	6.6
1973 and after.....	4.625	4.8	6.9	7.0

V. PUBLIC ASSISTANCE AMENDMENTS

1. *Increased assistance payments*

The Federal share of payments under all State public assistance programs is increased a little more than an average of \$2.50 a month for the needy aged, blind, and disabled and an average of about \$1.25 for needy children, effective January 1, 1966. This is brought about by revising the matching formula for the needy aged, blind, and disabled (and for the adult categories in title XVI) to provide a Federal share of \$31 out of the first \$37 (now twenty-nine thirty-fifths of the first \$35) up to a maximum of \$75 (now \$70) per month per individual on an average basis. Revises matching formula for aid to families with dependent children so as to provide a Federal share of five-sixths of the first \$18 (now fourteen-seventeenths of the first \$17) up to a maximum of \$32 (now \$30). A provision is included so that States will not receive additional Federal funds except to the extent they pass them on to individual recipients. Effective January 1, 1966. Cost: About \$150 million a year.

2. *Tubercular and mental patients*

Removes exclusion from Federal matching in old-age assistance and medical assistance for the aged programs (and for combined program, title XVI) as to aged individuals who are patients in institutions for tuberculosis or mental diseases or who have been diagnosed as having tuberculosis or psychosis and, as a result, are patients in a medical institution. Requires as condition of Federal participation in such payments to, or for, mental patients certain agreements and arrangements to assure that better care results from the additional Federal money. Provides that States will receive no more in Federal funds under this provision than they increase their expenditures for mental health purposes under public health and public welfare programs. Also removes restrictions as to Federal matching for needy blind and disabled who are tubercular or psychotic and are in general medical institutions. Effective January 1, 1966. Cost: About \$75 million a year.

3. *Protective payments to third persons*

Adds a provision for protective payments to third persons on behalf of old-age assistance recipients (and recipients on combined title XVI program) unable to manage their money because of physical or mental incapacity. Effective January 1, 1966.

4. Earnings exemption under old-age assistance

Increases earnings exemption under old-age assistance program (and aged in combined program) so that a State may, at its option, exempt the first \$20 (now \$10) and one-half of the next \$60 (now \$40) of a recipient's monthly earnings. Effective January 1, 1966. Cost: About \$1 million first year.

5. Definition of medical assistance for aged

Modifies definition of medical assistance for the aged so as to allow Federal sharing as to old-age assistance recipients for the month they are admitted to or discharged from a medical institution. Effective July 1, 1965. Cost: About \$2 million.

6. Retroactive benefit increase

The bill adds provision which would allow the States to disregard so much of the OASDI benefit increase as is attributable to its retroactive effective date.

7. Economic Opportunity Act earnings exemption

The bill also provides a grace period for action by States that have not had regular legislative sessions, whose public assistance statutes now prevent them from disregarding earnings of recipients received under the Economic Opportunity Act.

8. Judicial review of State denials

The bill provides for judicial review of the denial of approval by the Secretary of Health Education, and Welfare of State public assistance plans and of his action under such programs for noncompliance with State plan conditions in the Federal law.



March 23, 1965

Office of the White House Press Secretary

THE WHITE HOUSE

STATEMENT OF THE PRESIDENT

The Medical Care and Social Security Bill voted out today by the House Committee on Ways and Means is a tremendous step forward for all of our senior citizens. It incorporates all of the major provisions of the Administration's hospital insurance bill financed through social security which was introduced by Congressman Cecil King and Senator Clinton Anderson.

The Committee's action is an historic one -- the first time that a House Committee has acted favorably on a medical insurance bill for all of our older citizens. It is an action which all Americans can and should welcome.

Great credit goes to the hard-working members of the Ways and Means Committee and especially to the distinguished Chairman, Wilbur D. Mills, for the many weeks of work to make medical care protection for the older people of our nation a practical reality. Chairman Mills deserves special credit for his statesmanlike leadership in working out on a sound and practical basis a solution to one of the most important problems which has been pending before the Congress for nearly 15 years.

It is my hope that many Republicans will join with the Democrats in voting for this very fine bill. It is a bill which is financially sound and which will benefit the entire nation.

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SOCIAL SECURITY AND FEDERAL EMPLOYMENT

A REPORT REQUESTED BY
THE COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

SUBMITTED BY THE
UNITED STATES CIVIL SERVICE COMMISSION
AND THE
SOCIAL SECURITY ADMINISTRATION
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE



MARCH 13, 1965

NOTE: This report is being printed for informational purposes only

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LETTER OF SUBMITTAL

MARCH 13, 1965.

HON. WILBUR D. MILLS,
*Chairman, Committee on Ways and Means,
House of Representatives, Washington, D.C.*

DEAR MR. CHAIRMAN: Enclosed is the report of the Civil Service Commission and the Social Security Administration giving you the results of a study by these agencies of ways of filling gaps in retirement, survivors and disability protection of workers which arise because civilian employment for the Federal Government is not covered under social security. This report was requested by the Committee on Ways and Means in its report (H. Rept. 1799, 86th Cong.) on the Social Security Amendments of 1960 (H.R. 12580). The relevant part of the committee report follows:

Employees of the Federal Government constitute one of the last major groups of workers who do not have coverage available to them under the old-age, survivors, and disability insurance system. Your committee is aware that in certain cases this creates inequitable treatment and gaps in protection. It is also aware, however, that extension of coverage to this group will involve substantial policy questions and commitments by both the workers and the employer—the Federal Government. Your committee, therefore, urges that the appropriate Federal agencies concerned accelerate their efforts in finding a workable and sound solution to this problem and report it to the Congress at the earliest opportunity.

Various possible solutions to the problems your committee referred to in its report were analyzed with respect to their effect upon the overall benefit protection of persons with Federal employment—both long-term career civil servants and those who spend only a part of their working lifetimes in civil service work. Our analysis was concentrated on the six basic types of approaches which have been considered over the years for providing social security protection for Federal workers:

- (1) Extend social security coverage to Federal civilian employment, and make no adjustments in the civil service retirement system.
- (2) Permit present and future Federal civilian employees to elect social security coverage on an individual voluntary basis while continuing to be covered under the present provisions of the civil service retirement system. (Similar to approach No. 1, except that employee participation would be voluntary.)
- (3) Extend social security coverage to Federal civilian employment, with adjustments in the benefit level and contribution rates of the civil service retirement system which would take into account the contributions and benefits of social security.
- (4) Extend social security coverage to Federal civilian employment, with adjustments in the civil service retirement system (as under approach No. 3), but permit present employees to elect

to come under the new combined coverage or to continue under the present provisions of the civil service retirement system and not come under social security. Employees hired in the future would be compulsorily covered under social security and would be subject to the adjusted civil service retirement system provisions.

(5) Provide social security protection by means of transfers of credits from the civil service retirement system to social security in all cases where workers with Federal employment are not eligible for protection under the civil service retirement system upon their reaching retirement age, severe long-term disablement, or death.

(6) Provide social security protection by means of transfers of credits (as under approach No. 5) but only in the case of workers who separate, die, or become disabled with less than 5 years of Federal employment.

On the basis of our exploration of the advantages and disadvantages of these six approaches, a transfer-of-credit plan which follows approach No. 5 appears to offer "a workable and sound solution" to the problem of filling gaps in the protection of workers who have Federal employment. It does not, on the other hand, have certain advantages that some coverage-coordination plans have. This approach would require no changes in the provisions of the civil service retirement system, other than provisions for financing the plan, and would avoid difficulties which so far have prevented legislative action in this area. Thus, by providing benefit protection under social security in all situations where, under present law, no benefits would be payable under the civil service retirement system, the plan would close major gaps in the protection of workers who have Federal employment and would, moreover, be a relatively inexpensive approach.

Under this transfer-of-credit plan, credit for the Federal employment of workers who die, become disabled, or leave work covered under the civil service retirement system with less than 5 years of work under that system would be transferred to social security. (In this type of situation, the separated employees have no disability or survivorship protection under the civil service system.) Also, the credits of workers who leave Federal employment with more than 5 years of work covered under the civil service retirement system, and who lose their benefit protection under that system, would be transferred to social security. Appropriate financial adjustments between the two systems would be made to take account of the transfers of credit.

The Advisory Council on Social Security recently completed its study of the social security program and reported its findings and recommendations. In respect to social security protection for Federal employees, the Council recommended a transfer-of-credit plan that is similar to the one described above.

We recognize that this approach has shortcomings. For example, approach No. 5 would provide social security survivor and disability protection for workers with less than 5 years of Federal service which would be better than the survivor and disability protection afforded many of the workers with more than 5 years of service under the civil service retirement system. To correct this situation would require changes in the survivor and disability protection now provided by the civil service retirement system, perhaps by adding to a transfer-of-

credit plan a provision guaranteeing benefit amounts that would be no less than those that would be paid under social security. Also, a transfer-of-credit plan would have no effect in situations where workers qualify for benefits under both social security and the civil service retirement system in total amounts which may be considered high in relation to the worker's lifetime earnings and contributions.

The administration is at present making a comprehensive study of retirement provisions for Federal personnel. This study will include further consideration of the role of social security in the protection afforded Federal personnel through social security and the civil service and other staff retirement programs. The Cabinet committee established to make this study has been asked to report to the President by December 1, 1965.

Sincerely,

JOHN W. MACY, Jr.,
Chairman, U.S. Civil Service Commission.

ROBERT M. BALL,
Commissioner of Social Security.

SOCIAL SECURITY AND FEDERAL EMPLOYMENT

We have in the United States adopted the broad public policy that, as far as possible, all who work should be assured that family income will continue when the worker's earnings are cut off by retirement, severe long-term disablement, or death. Through our social security system, which covers 9 out of 10 jobs, basic protection against these major threats to continuance of family income follows the worker who moves from one job to another and from one industry to another. But there is still one major sector of the economy—civilian employment for the Federal Government—where worker mobility is penalized by loss or impairment of this basic protection.

GAPS IN PROTECTION RESULTING FROM FEDERAL EMPLOYMENT

Because most Federal civilian employment is not covered under social security and because the civil service retirement system is designed with main emphasis on benefit-protection for long-service Federal employees,¹ there are substantial gaps in the retirement, survivor, and disability protection of people whose work lifetimes are divided between Federal service and other work. Many of those coming into Federal employment lose social security rights they earned in previous work. Of those who leave, only a small fraction retain any protection under the civil service retirement system, and relatively few get any protection under social security as a result of their Federal employment.

There is considerable worker mobility between Federal employment and other work. Over the last decade, the average number of persons entering Federal employment has been in excess of 400,000 a year, and the average number of persons leaving² (including some 50,000 retirements and deaths a year) has been roughly the same. Since most of this turnover involves shifts between coverage under social security and the civil service retirement system, millions of workers and their families have had a loss or impairment of protection.

The 2.3 million Federal civilian employees who are under Federal staff-retirement systems are the only large group of workers who do not have social security protection. Social security coverage is provided for almost all other employees, whether in Government or private industry, and many are covered by staff-retirement systems

¹ The Federal civil service retirement system provides retirement annuities for Federal employees who have completed at least 5 years of service and meet other conditions. It provides disability and survivors protection for those employees who have at least 5 years of service and who are still in the employ of the Federal Government at the time of their disability or death. (App. A contains a summary of provisions of the civil service retirement system.) There are also several small Federal staff-retirement systems (such as the Foreign Service retirement system) which, however, have less in-and-out movement of workers and hence the problems of gaps in protection are less serious. Whatever approach might be used to fill gaps in the protection of workers in employment under the civil service retirement system could be adapted to most of the small systems as well.

² App. B, table 1.

as well. In private industry some 35,000 pension plans are built on social security. The retirement system for railroad workers is coordinated with social security. Over 4 million of the 6¼ million employees of State and local governments are now covered under social security, and about three-fourths of those under social security are also covered by public staff-retirement systems. Social security coverage has also been extended to the 2.7 million members of the Federal uniformed services, who are also covered under staff-retirement plans, to about 200,000 Federal civilian employees (mainly temporary employees) not under a Federal staff-retirement system, and to 18,000 employees of the Tennessee Valley Authority, of whom about 11,000 are under a staff-retirement system.

Almost all of the 2.3 million Federal civilian employees who are excluded from social security are subject to the civil service retirement system,³ the principal staff-retirement system for civilian employees of the Federal Government. In accord with its purpose of encouraging qualified employees to make a career in Federal service, the system provides excellent protection for employees who have completed long periods of service. With significant exceptions in the area of disability benefits (and, to a lesser extent, survivor benefits) benefits under the civil service retirement system are closely related to both the employee's length of service and the amount of his pay.⁴ The system is currently financed by employee contributions of 6½ percent of pay and by a matching contribution from the Government. Over the long run, however, the level cost of the system on a "normal cost plus interest" basis is estimated to be 22.33 percent of payroll (of which 6½ percent is contributed by employees and the remaining 15.83 percent is the cost to the Government). The normal cost (13.49 percent of payroll) is defined as the average percentage of the salaries of new employees that is required to be paid into the civil service retirement and disability fund from the time they enter service until they leave service in order to accumulate sufficient amounts to pay their benefits. When the fund was originally established, employees were given credit for their prior service during which "normal cost" had not been paid, thus creating a "deficiency" liability, which has grown through the years for various reasons, such as liberalization of benefits, including benefits based on prior service. Annual interest on the deficiency (at 3½ percent) amounts to 8.84 percent of payroll, so that the two items (normal cost and interest) add to 22.33 percent of payroll required for level financing of the system.

Survivors and disability protection

During the first 5 years of Federal employment, workers and their families have no survivors or disability protection under the civil service retirement system and any social security protection based

³ As indicated in footnote 1, a relatively small number of Federal employees are covered under one of several other staff retirement systems, such as the Foreign Service retirement system.

⁴ To illustrate, the retirement benefit of a worker with 5 years of service is 7½ percent of pay (averaged over the 5 years) while that of a worker with 30 years of service is about 56 percent of average pay (based on the 5 years of highest earnings). Benefits to workers who become totally disabled after at least 5 years of service and who entered Federal service prior to age 38 are not less than 40 percent of average pay during the highest 5 years. The widow of an employee who dies after 5 years of service gets about 4 percent of his average pay (based on his 5 years of highest earnings); the widow of a 10-year employee, about 9 percent; and the widow of a 30-year employee, about 31 percent. However, flat amounts are provided for surviving children—generally \$50 a month, but less if there are more than 3 children and more if no widow or widower survives.

on previous work is likely to be lost or impaired.⁵ Survivors of an employee who dies before completing 5 years of service get a refund of the worker's contributions to the civil service retirement system.⁶ In some instances—those in which the deceased worker is still insured for social security survivor protection on the basis of having worked under social security before he entered Federal service—the survivors can get social security benefits; but the social security benefit amounts will not reflect his recent earnings and may be quite low because of the period of time that the worker spent in noncovered employment. Similarly, the worker who becomes totally disabled during his first 5 years of Federal service has no protection under the civil service retirement system. Federal civilian workers who become disabled during this period, and their families, are even less likely than in the death cases to qualify for social security disability protection because to be insured for this protection the disabled worker must have had recent, as well as substantial, work covered by social security.⁷ At a given time, about 14 percent of employees under the civil service retirement system have less than 5 years of service.⁸

Even though they have worked 5 or more years in Federal employment covered by the civil service retirement system, all workers who leave that employment before retirement cease to have survivor and disability protection based on their years of Federal service. A very high proportion of these workers—and there are many thousands each year—not only lose their survivor and disability protection under the civil service retirement system but also are without social security protection (either because they never worked under social security or because they have not worked under social security for some time) and will continue to be without such protection for some time to come.⁹

Retirement protection

Of those workers who leave Federal service before retirement, only a small minority will receive a retirement benefit based on their Federal service.

A 1961 study of people who left work covered by the civil service retirement system (other than persons who retired or died) showed that less than 8 percent gained and retained any protection under the civil service retirement system as a result of their Federal service. About

⁵ To be eligible for disability protection under social security a worker must be in covered employment for at least 5 years in the 10-year period before he becomes totally disabled, and must also be fully insured—that is, he must have been in covered work for a period equal to about one-fourth of the time after 1950 (or age 21, if later) and up to the time he becomes totally disabled. The minimum requirement for fully insured status is about 1½-years of covered work; the eventual minimum will be 10 years of coverage. To be eligible for survivors' protection, a worker must be either fully or "currently" insured. He becomes currently insured by working in covered work for approximately 6 months in the 6-year period immediately preceding his death. If the worker is currently, but not fully, insured, widow's benefits, mother's benefits, and a lump-sum death payment can be paid. Benefit amounts are based on average earnings credited under social security. The years a worker spends in Federal service not covered by social security tend to diminish his average earnings for the purposes of the social security benefit computation, and therefore the benefit amount to which he or his family may become entitled.

⁶ Upon separation, including separation because of death, from work covered by the civil service retirement system after less than 5 years of service, the employee's contributions to the system (6½-percent of pay) are refunded with interest. Almost all employees also are covered under Federal employees' group life insurance, to which they contribute about two-thirds of 1 percent of pay. This plan pays approximately 1 year's salary to survivors, with double indemnity in case of accidental death, and includes benefits for accidental dismemberment. This protection stops when an employee leaves Federal service (except upon career or disability retirement or while receiving compensation for service-connected disability, when life insurance continues free), subject to a 31-day extension of life insurance during which he may convert to an individual life insurance policy at standard rates without a medical examination. Service-connected disability or death is compensable under the Federal Employees' Compensation Act.

⁷ See footnote 5.

⁸ See app. B, table 2.

⁹ See footnote 5.

two-thirds of those who left did so before they had worked 5 years and thus did not meet the minimum requirements for protection under civil service retirement. Of those employees who separated from Federal employment after 5 years or more of Federal work, but before retirement, 77 percent withdrew their contributions within 6 months after they separated¹⁰ and thereby lost all rights to benefits under civil service retirement. (See table 3 in app. B.) These rights may be regained only if the worker is reemployed in work covered by the system.

According to the 1961 study, almost 60 percent of the people who separated from Federal service and withdrew their contributions to the civil service retirement system were men. While the men who end up getting no retirement benefits under the civil service retirement system on the basis of their Federal service may qualify for social security benefits, these benefits will usually be lower because they will not reflect their years of Federal service. The same is, of course, true of the social security benefits that women earn in their own right. Married women are in a somewhat different position than single women, since a married woman who withdraws her contributions will have some retirement protection through the social security wife's benefit based on her husband's work.¹¹

As can be seen from the above analysis, whether the benefit protection obtained by the millions of employees whose work lifetimes are divided between jobs under social security and work covered by the civil service retirement system is adequate may turn on the element of chance. In many cases, the worker does not become eligible for benefits under one of the systems, and therefore the years of service and the earnings he had under that system do not count in figuring the benefits he and his survivors will get. Some workers may end up without eligibility for benefits under either system; for example, workers may surrender their protection under the civil service retirement system by withdrawing their contributions and not work long enough in other employment to qualify for social security benefits.

Those who qualify for both social security and civil service retirement benefits

On the other hand, some persons may qualify for benefits under both systems in a total amount which seems unreasonable in relation to their total earnings and contributions.

Social security benefits, being based on social insurance principles, are heavily weighted to provide benefits to low-paid earners that are relatively high in relation to earnings and contributions. Under present law, the formula underlying the benefit tables provides 58.85 percent of the first \$110 of creditable monthly earnings and 21.4

¹⁰ Many people who do not initially withdraw their contributions may later decide to do so. Statistics of the U.S. Civil Service Commission indicate that in recent years an average of only 4,000 people per year come on the civil service retirement rolls for deferred annuities. The number of persons separating from Federal employment (most of whom were not under the Civil Service Retirement Act and had less than 5 years of service) has been no lower than 340,000 in any year since the beginning of World War II, and in several years during the 1940's was well in excess of one million.

¹¹ The social security wife's benefit equals one-half of her husband's benefit. A woman entitled both as a worker and a wife receives an amount equal to the larger of the two benefits. Social security coverage may be quite valuable to a married woman. Her entitlement to benefits on her own account is not affected by various contingencies that apply to wife's or widows' benefits. For example, a woman who had earlier anticipated receiving a wife's benefit may not be eligible because she has in the meantime become divorced or because her husband has failed to qualify for social security benefits. Also, if the woman is older than her husband, her own work may provide her with social security benefits prior to the time her husband qualified for benefits. Another consideration is that a woman may not receive a wife's benefit when she reaches retirement age (but would be eligible to receive her own benefit as a retired worker) if her husband continues to work after he reaches retirement age. Moreover, women may through their own work acquire valuable disability and survivors protection which they cannot acquire on the basis of a husband's work.

percent of the next \$290 of earnings. In addition, social security pays a minimum monthly benefit of \$40 a month to an insured retired worker who comes on the rolls at or after age 65, and a minimum of \$60 for such an insured worker with one dependent (a child, or a wife aged 65 or over), with corresponding minimum benefits for surviving dependents. As a result of this weighted benefit formula, persons who generally work in employment not covered by social security but have enough social security coverage to qualify get an advantage in the benefit-contributions relationship that is intended for low-paid workers. For example, even highly paid Federal career employees with substantial civil service retirement benefits can, through regular or part-time employment, acquire the required 40 quarters of coverage under social security (fewer quarters are now required for older workers) and with very low creditable earnings (average monthly earnings under social security of \$67 or less) can qualify for the minimum benefits.

This problem is not unique to Federal employment, of course, but exists with respect to all noncovered employment.

PREVIOUS EFFORTS TO FIND A SOLUTION AND THE EFFECT OF CHANGES
IN THE CIVIL SERVICE RETIREMENT SYSTEM ON PRESENT CON-
SIDERATION

The problems arising because of the exclusion from social security of work covered by the civil service retirement system have long been recognized. The 1938 Advisory Council on Social Security recommended that studies be made of the problems involved in extending social security coverage to Government employees. The 1948 Advisory Council on Social Security recommended to the Senate Committee on Finance that as a temporary measure the wage credits of Federal employees who die or leave Federal employment with less than 5 years' service should be transferred to social security, and that a permanent plan should be developed for covering Federal civilian employees under social security. The Committee on Retirement Policy for Federal Personnel (the Kaplan Committee) in 1954 recommended that civilian employees of the Federal Government be covered under social security, with appropriate adjustments to be made in the civil service retirement system.¹² In 1956, the Eisenhower administration recommended that Congress enact proposed legislation based on the Kaplan Committee study.

The Social Security Administration and the Civil Service Commission have also given much attention over the years to alternative plans for providing social security protection for Federal employees. The issues in developing a satisfactory proposal are somewhat different now than they were at the time of the Kaplan Committee study because of the improvements that have been made in the civil service retirement system during the last decade.

The more important changes that have been made in the provisions of the civil service retirement system (by legislation enacted in 1956 and 1962) are: (a) increase in the basic annuity formula from $1\frac{1}{2}$ percent of high-5-year average pay for each year of service to $1\frac{1}{2}$ percent for each of the first 5 years of service, $1\frac{3}{4}$ percent for each of the next 5 years, and 2 percent for each year of service after the 10th; (b) provision of a guarantee (generally speaking) of 40 percent of

¹² App. E describes this recommendation in some detail.

high-5-year average pay for employees under age 60 qualifying for disability annuities; (c) improvement of survivor annuities; (d) provision for automatic cost-of-living increases for annuitants; and (e) increase in the employee contribution rate to $6\frac{1}{2}$ percent of pay, compared with 6 percent in 1954. In 1954, the cost of the civil service retirement system was estimated at 15.70 percent of payroll—11.15 percent was the normal cost and 4.55 percent was a deficiency cost. At present, the cost estimate is 22.33 percent—13.49 percent normal cost and 8.84 percent deficiency cost (described on pp. 10-16).

As one result of these changes, the retirement benefit amounts of career employees have been substantially improved. Thus, for a worker retiring after 35 years of service the retirement-benefit formula in effect in 1954 generally provided a benefit amounting to $52\frac{1}{2}$ percent of his high-5-year average pay. The present formula provides $66\frac{1}{4}$ percent of high-5-year average pay for the retired worker with 35 years of service. The provisions for automatic increases in benefit amounts to take account of cost-of-living increases also represent a significant improvement in the protection provided by the civil service retirement system.

These changes have also increased the cost of the system to a point where the cost of further improvements in the level of protection provided long-term career employees raises questions as to what the public policy should be as to what proportion of the compensation of Federal employees is to be in the form of deferred compensation. There is also a question as to whether employees' contributions should be increased beyond the $6\frac{1}{2}$ percent of pay they now contribute to the civil service system, considering, among other things, that most employees also make payments under the Federal employees' health insurance program and the Federal employees' life insurance program.

APPROACHES CONSIDERED IN THE PRESENT STUDY

In carrying out the request of the Committee on Ways and Means, we explored various general approaches to the problem of gaps in the protection of people who have Federal employment, and a number of tentative plans based on these general approaches. This section of the report describes the general approaches considered, and the principal considerations underlying each.

Approach No. 1.—Extend social security coverage to Federal employment covered by the civil service retirement system without making any changes in the provisions of the retirement system. (This approach is sometimes referred to as the "fully additive" approach.) Employees would continue to pay contributions to the civil service retirement system at the present rate ($6\frac{1}{2}$ percent of total pay) and would also pay social security employee contributions;¹³

¹³ Social security contribution rates for employees and employers provided under present law and under H.R. 1 (the proposed Hospital Insurance, Social Security, and Public Assistance Amendments of 1965) are as follows:

Years	Employee-employer (each)	
	Present law	H. R. 1
1966-67.....	4.125	4.25
1968-70.....	4.625	5.0
1971 and after.....	4.625	5.2

Present law covers the first \$4,800 of annual earnings; H. R. 1 would cover the first \$5,600.

there would be no reduction in the Government's cost in respect to the civil service retirement system, and the Government would, in addition, pay social security employer contributions. Employees would receive all benefits payable under the present civil service retirement system as well as those payable under social security. (For illustrative monthly benefits payable under a fully additive plan, see app. C.)

Considerations

(a) This approach would go beyond filling gaps in the retirement, survivor, and disability protection of those who shift between Federal employment and other work and would provide benefit amounts which for many career employees would be very high when compared with prior earnings levels. Since Federal workers could get full benefits under both the civil service retirement system and the social security system, it would not be rare, under this approach, for Federal workers to retire with benefits that equal or exceed their salaries.

Example A.—An individual works in Federal employment from age 25 to 65, with final salary of \$500 a month. Under the fully additive approach, and assuming the social security benefit provisions of present law, a retired worker and his wife, after she reaches 65, would get total benefits of \$557¹⁴ a month in civil service and social security benefits, or more than 110 percent of salary; the single worker would get \$508 a month.

Example B.—After 5 years in a job in private industry an individual works in Federal employment for 5 years averaging \$420 a month and then becomes totally disabled. He has a wife and one young child. Under the fully additive approach, the family would get monthly benefits of \$442 a month or slightly more than his salary.

(b) The fully additive approach would be the most costly for employees and the Government. Under the social security contribution rates scheduled under present law, employees would soon be required to pay an additional 4.625 percent of the first \$4,800¹⁵ of their annual pay, and these contributions would have to be matched by the Government. Even assuming that neither the civil service retirement contribution rate nor the ultimate social security contribution rate increases in the future, employees would be paying in excess of 11 percent of pay up to \$4,800 a year toward protection under civil service retirement and social security. For the Government, the additional cost of providing protection under the fully additive approach would amount to more than 3 percent of payroll, or about \$500 million a year.

(c) The fully additive approach has been used in extending social security coverage to some Government employees.¹⁶ Some State and local government retirement systems have added social security coverage without adjusting the provisions of the staff-retirement systems. In most such cases, however, the staff-retirement system

¹⁴ Based on the assumption that the worker accepted a reduced CSR annuity in order to provide CSR survivor protection for his wife. If such provision were not made, the total benefits would amount to \$572 a month for the worker and his wife.

¹⁵ 5.2 percent of the first \$5,600 under H.R. 1.

¹⁶ When social security coverage was extended to the Federal uniformed services (1956), various existing survivor provisions were adjusted to take the social security coverage into account but no reduction was provided in the retirement benefits under the existing staff-retirement systems. One consideration was that the formula for computing the retirement benefits—both the social security benefits and the staff-retirement benefits—of members of the uniformed services is applicable to service base pay and thus does not reflect the value of noncash items which represent a substantial part of the total pay of most servicemen. In most cases a serviceman's total pay, including allowances or the value of quarters and food, exceeds his base pay by 30 percent or more.

benefits payable were low, and when social security benefits were added the resulting total was generally well below the level which would be reached by adding social security benefits to those of the Federal civil service retirement system.¹⁷

(d) A consideration which would be applicable to any plan involving compulsory social security coverage of Federal employees is that some employees, because of their personal situation, believe they would not receive enough additional financial advantage from the social security coverage of their Federal work to make it personally advantageous to pay the scheduled contribution rates.

(i) In the case of some persons who expect to stay in Federal employment until they retire but who expect to qualify also for social security benefits on the basis of non-Federal work, the social security coverage of their Federal work may not be particularly advantageous. Persons with Federal employment who qualify for social security benefits based on only a small part of their lifetime earnings have low average monthly earnings for social security purposes, and will gain the advantage of the weighted benefit formula which is intended to provide a relatively high benefit return for people who actually have low average earnings over a lifetime. As a result of this and other social security provisions, the increases in social security benefits from the coverage of Federal work for people who will qualify for social security benefits based on non-Federal work would not be as large relative to the social security taxes they would pay on the basis of their earnings from Federal employment as in the case of the benefits which would be payable without Federal coverage; however, for most such employees the additional social security benefit amount would still represent a good buy for the employee.

(ii) In many cases, women workers who expect to qualify for a wife's social security benefit (or widow's benefit, in the event their husband's death precedes theirs) believe social security coverage of their own work would not be of enough advantage to make it personally advantageous to pay the social security contributions.¹⁸

(iii) Some older employees who have had no previous social security coverage may expect that they will not be covered under social security long enough to become insured before they retire.

Approach No. 2.—Provide social security coverage for Federal employees on the basis of individual choice, without any changes in

¹⁷ An exception is the New York State Employees' Retirement System. Employees covered by this system and by social security can qualify for benefits which represent a relatively high proportion of pay. The State system offers the employee a choice between an "age 55" plan, which is designed to give him "half-pay" retirement benefits (based on the average of his salary in his last 5 years of service) after 30 years of service at minimum age 55, and an "age 60" plan, which is designed to give him "half-pay" retirement benefits after 35 years of service at minimum age 60. (The "half-pay" is made up of two elements—a pension financed by the State, and an annuity financed partly by the State and in many cases wholly by the State.) As compared to the "half-pay" benefits the State system is intended to produce, the Federal civil service retirement system pays retirement annuities of 56¼ percent of the high-5-year average salary after 30 years of service, and 66¼ percent after 35 years of service. Social security coverage was extended to employees covered by the New York State Employees' Retirement System on Sept. 30, 1957, under a provision which permitted all current employees to choose whether to come under social security while continuing to be covered under the State system; employees hired after Sept. 30, 1957, are covered under social security (and the State system) on a compulsory basis.

¹⁸ As noted earlier, a social security wife's benefit is equal to one-half of the husband's benefit, and, in general, a woman entitled to wife's benefits and benefits because of her own work gets an amount equal to the larger of the two. A widow at age 62 receives a benefit equal to 82½ percent of the benefit her husband would have received; a younger widow (with a child entitled to benefits in her care) get three-fourths of the husband's benefit. Some women may feel that the increased amounts they would get because of coverage of their own work would not be enough larger than a wife's or widow's benefits to warrant paying the social security contributions. However, protection based on their own work may be quite valuable for them. (See footnote 11.)

their protection under the civil service retirement system. This approach is the same as approach No. 1 except that employee participation would be on an individual voluntary basis. Employees electing social security coverage would pay social security employee contributions (in addition to their contributions to the civil service retirement system); the Government, as employer, would pay social security employer contributions in respect to those employees who elected coverage.¹⁹

Considerations

(a) The considerations discussed under approach No. 1 relative to high benefits and costs are also applicable to this approach, except that total employer costs would not be as large as under approach No. 1 because not all employees would elect social security coverage. However, the high employer cost for some employees would be even less justifiable than under approach No. 1 because the additional expenditures by the Government as employer, under this approach, would go mostly toward raising the benefits (sometimes to the point of paying retirement benefits in excess of earnings) of the better paid career workers (who would be in a better position to assume the cost of social security employee contributions). If Government costs are to be increased it would not seem desirable to have the increased expenditures go to provide higher benefits for those who can afford, and take the initiative to elect, social security coverage. Moreover, because some employees would not elect coverage, the aim of filling gaps in protection for those who move in and out of Federal work would not be fully achieved.

(b) Proposals to provide individual voluntary coverage under social security have been considered from time to time by the Committee on Ways and Means and the Committee on Finance and it was always concluded that social security coverage on an individual voluntary basis is undesirable. The same conclusion was reached by the 1965 Advisory Council on Social Security.²⁰ In its report the Council states: "It is essential that the coverage of the program remain on a compulsory basis. If coverage were voluntary, the program could not effectively carry out its purpose of providing basic protection for all. The improvident would not be inclined to elect coverage. Many workers who have great need for protection and limited opportunity to acquire it through private means—low income workers, workers with large families and workers in poor health—would choose not to pay social security contributions because of pressing day-to-

¹⁹ Under a somewhat similar plan which is favored by some Federal employees, social security coverage would be made available to Federal employees on the basis of individual choice, in addition to their coverage under the civil service retirement system, and those electing coverage would be covered under the social security provisions designed for the coverage of self-employed persons. (The social security contribution rate for self-employed persons is 1½ times the employee rate, and equals three-fourths the combined employee-employer contribution rate.) Apart from the objections to providing social security coverage on a continuing individual voluntary basis, this plan would have other objectionable features. Such a plan would (a) except the Government, as employer, from its obligation, imposed by law on other employers, to bear part of the cost of social insurance for its employees, (b) impose on the employees a higher cost burden than that borne by other employees, and (c) result in an unwarranted and unsound reduction in the contribution rate received by the social security system for Federal employees below the rate applying to wage or salary employment generally.

²⁰ The Advisory Council on Social Security, composed of distinguished representatives of business, labor, self-employed people, and the general public, made a comprehensive review of the social security program and on Jan. 1, 1965, issued its report, "The Status of the Social Security Program and Recommendations for Its Improvement." As required by law, the Advisory Council was appointed by the Secretary of Health, Education, and Welfare in 1963 to study all aspects of the social security program, including the financing of the program, extensions of coverage, and the adequacy of benefits, and to make a report of its findings and recommendations. The Council's statement concerning individual voluntary coverage appears on pp. 74-75 of its report.

day needs. Moreover, permitting individual voluntary coverage would increase program costs and give those allowed such coverage an unfair advantage over workers who are covered on a compulsory basis."

(c) Employees and groups of employees other than civilian employees of the Federal Government have expressed interest in being permitted to choose on an individual basis whether or not to be covered under social security. If the Federal Government were to permit continuing individual voluntary coverage for its own employees, other workers would have a strong case for requesting the same treatment. Thus, approach No. 2 could lead to individual voluntary coverage in additional employment areas, compounding the problems which result from the voluntary coverage of Federal employees.

Approach No. 3.—Extend social security coverage to Federal employment covered by the civil service retirement system, with some reduction in benefits and contributions under the civil service system to take account of the contributions and benefits of the general social security system (sometimes described as a "coverage-coordination" approach).²¹ To be acceptable, a plan which follows this approach would have to be designed so that the protection provided under the civil service retirement system, plus the protection provided under social security on the basis of covered work, would always be at least equal to and usually somewhat superior to that provided under the present civil service retirement system alone.

Considerations

(a) This approach more than any other has the potential for assuring a reasonable relationship between benefits and lifetime contributions and service in the case of people who shift between Federal employment and other work. Since the benefit level of the civil service retirement system would be modified so that the level of benefits provided under it would be based on the assumption that social security benefits would also be payable, the combined benefits (and also the combined contributions) would be at a planned and systematic level.

(b) A coverage-coordination plan, with employees qualifying for independently computed benefits²² under social security and civil service retirement based on the same period of Federal service, seems certain to require further increases in certain benefits, particularly retirement benefits for many long-term career employees, which have already been considerably increased in recent years (discussed on pp. 5 and 6). Such increases would result because of the need to avoid deliberalizing present benefits for some employees. To illustrate one of the various problems in designing a plan of this kind, if an unmarried worker's civil service retirement annuity is reduced under a given formula so that the total of his reduced annuity and his social

²¹ This approach is the one that has been most commonly used to provide protection under social security and a staff-retirement system in private industry, State and local government, and other areas of employment—that is, the most common pattern is that the protection under the staff-retirement system is designed to be a supplement to the basic protection that the employees have under social security. It is the approach proposed by the Kaplan Committee in 1954. (See app. E.)

²² An offset method of coordination, under which civil service retirement benefits would be reduced by a specified percentage of whatever social security benefits are earned in Federal employment, would be somewhat more efficient than independently computed benefits from the standpoint of providing consistent treatment in all cases. However, it would seem to link the civil service retirement system very closely with social security—a point on which some Federal employee organizations have expressed the greatest concern. The use of the offset method in private industry is, in general, confined to systems to which the employee does not contribute.

security benefit is slightly in excess of the civil service retirement annuity provided under present law, the same formula will, in effect, give a married worker with a somewhat similar record of earnings and service a substantial increase because of the social security wife's benefit that will be payable to his spouse. For example, under the coordination plan in appendix D, the same benefit-computation formula which would provide an increase of less than 5 percent in retirement benefits to a \$6,000-a-year single worker with 32 years of Federal service would provide an increase of about 22 percent in the retirement benefits (including social security wife's benefits) of a \$6,000-a-year married worker with 40 years of Federal service.

Thus if the adjusted civil service retirement benefits are set high enough to assure that the total of the civil service and social security benefits will be at least as high as present civil service benefits in all instances, large increases, which seem difficult to justify, would result in the combined benefits which would be payable in some cases. Though the increase in the cost would not be as large as under fully additive coverage, this approach, as a practical matter, would involve increasing costs beyond what is necessary to merely fill gaps in existing protection. For example, the total additional cost of the plan illustrated in appendix D is estimated at 2.63 percent of civil service payroll and that plan may be very close to the lowest cost coverage plan that would not deliberalize present protection and would be reasonably simple and understandable.

(c) This approach in particular has been strongly opposed by organizations of Federal employees, who apparently feel that, once social security coverage is provided and benefits under the civil service retirement system are reduced, the role of the civil service retirement system in providing protection for Federal employees would become much less important. Presumably, they believe that it would be more difficult or even impossible to obtain congressional action to improve the special staff retirement features of the civil service retirement system for long-term career employees once Federal employees are provided with the protection of the generally applicable social security system, and that further improvements in their retirement, survivors, and disability protection would tend to be limited to those made in the social security system.²³

Also, aside from the possible long-range effect of the proposal upon civil service retirement system benefits in general, many present Federal employees with long service apparently believe that even initially the legislation modifying the civil service retirement system would be such that, looked at from a personal point of view, their overall protection would not be increased enough to make such coverage desirable for them. In addition to situations discussed earlier where social security coverage may not seem very advantageous to some individuals—for example, married women and Federal employees who have social security coverage through other work—annuitants under the civil service retirement system can earn any amount in non-Federal work without such work affecting their annuities, whereas social security beneficiaries may have their benefits, or part of them, withheld under a retirement test which applies to

²³ However, in private industry and other areas of employment many good staff-retirement systems are maintained as supplements to social security coverage and staff-retirement provisions have been improved to further benefit long-service employees.

all earnings.²⁴ Therefore, long-term career Federal employees who expect to work in non-Federal employment after reaching the age at which they could receive their social security benefits (age 62 for reduced benefits, age 65 for unreduced benefits) anticipate that they would lose by getting only the reduced benefit under the civil service retirement system, and no social security benefit, for a period of time after they leave Federal employment.

Approach No. 4.—Extend social security coverage to Federal employment, with modifications in the provisions of the civil service retirement system, but permit current employees to elect to come under the combined coverage or to continue under the present provisions of the civil service retirement system and not come under social security. Employees hired in the future would be compulsorily covered under social security, and would also be covered under the provisions of the civil service retirement system as modified to take into account social security protection. This approach is the same as approach No. 3 except for the option afforded current employees. One of the various ways in which this approach could be implemented is illustrated by the detailed plan in appendix D.

Considerations

(a) This approach is designed to meet objections, discussed earlier, of many present employees who do not want their Federal work covered under social security, such as workers already insured under social security whose benefits would not be greatly increased by additional coverage, married women who expect to get social security wife's benefits, and workers near retirement age who might not be covered long enough to become insured, and others who do not see enough personal advantage in social security coverage to want to pay the contributions.

(b) Provisions under which current employees are given a choice as to social security coverage and future employees are compulsorily covered have been applied quite successfully to employees of State and local governments in a number of States. Such provisions are not subject to the objections to permitting voluntary social security coverage on a continuing basis, since the adverse effects on the social security program would be temporary and therefore relatively minor.

(c) This approach, just as in the case of approach No. 3, would require nonessential increases in certain benefits, particularly benefits for many long-service career employees, in order to avoid deliberalizing benefits for some employees. As in the case of approach No. 3, costs would be increased beyond what is necessary to fill gaps in protection.

(d) This approach, as in the case of approach No. 3, has been opposed by organizations of Federal employees, since there would be a reduction in benefits provided by the civil service retirement system. (These objections are discussed on p. 15.) In addition, under approach No. 4 there would be a group of employees who would not elect social security coverage, but would continue under the present provisions of the civil service retirement system. Since the number of workers so covered would gradually decline with the passage of time, there may be even more concern than in the case of approach

²⁴ Under the social security retirement test, old-age and survivors insurance benefits are paid to people under age 72 only if they are substantially retired from work. Generally speaking, a beneficiary who earns less than \$1,200 in a year receives all his social security benefits; a beneficiary who earns more than \$1,200 in a year has \$1 in benefits withheld for each \$2 in earnings between \$1,200 and \$1,700, and for each \$1 for earnings above \$1,700.

No. 3 that it would be difficult to obtain further improvements in the civil service retirement system.

Approach No. 5.—Provide for transfers of credit for Federal employment to social security under a plan which would be broad enough to provide social security protection for all workers with Federal employment who are not eligible for protection under the civil service retirement system when they reach retirement age, become disabled, or die. This is the approach which was recommended by the 1965 Advisory Council on Social Security. (See app. G.) A transfer-of-credit arrangement is included as part of the present railroad retirement-social security coordination.²⁵

Considerations

(a) This approach would fill major gaps in the present survivor, disability, and retirement protection of those who spend part of their work lifetimes in Federal employment but do not continue to have protection under the civil service retirement system after they leave Federal employment. All such persons who are not protected under the civil service retirement system upon death, disablement, or retirement would have social security protection based on their Federal work (as well as other work).²⁶

(b) This approach would be much less expensive than approaches involving extension of coverage to Federal employment. The additional cost of a minimum-type "coverage-coordination" plan under approaches No. 3 and No. 4 (app. D) is estimated to be 2.63 percent of civil service payroll, and the fully additive approaches identified as approaches No. 1 and No. 2 would be even more expensive. The additional cost of a transfer-of-credit proposal consistent with approach No. 5, however, is estimated to be only about 1 percent of civil service payroll. This is true because the transfer-of-credit plan does not increase benefits of long-term career employees who stay in the Federal service. However, even those employees would have had valuable survivor and disability protection under social security during their early years of service.

(c) This approach would avoid the relatively high combined benefits which would result in some situations from coverage-coordination plans and more frequently from plans which would provide social security coverage without any adjustments in civil service retirement benefits.

(d) A transfer-of-credit plan would require no modification of the provisions of the civil service retirement system, other than to make provision for financing the plan. Thus, a transfer-of-credit plan would not affect the benefits of long-term career employees who stay in the Federal service, and could not reasonably be opposed as interfering

²⁵ The railroad retirement-social security coordination provides for the transfer of credits from the railroad program to social security upon the death, disablement, or retirement of a worker with less than 10 years of railroad work. In survivors cases in which the worker had 10 or more years of railroad employment, records are combined: If the worker had a current connection with the railroad industry at the time of his death, or at the time he becomes entitled to a retirement annuity, social security credits are transferred to the railroad retirement program, and payment is made by that program; if there is no current connection with the railroad industry, railroad credits are transferred to social security, and payment is made by that program. The survivor provisions of the railroad retirement program are modeled after and are almost identical with the survivor benefit provisions of social security, a fact which makes it reasonable to transfer credits in either direction. An across-the-board minimum benefit guarantee based on the social security benefit formula applies to all beneficiaries under the railroad program. Also, railroad benefits are, in effect, reinsured under social security by provisions in the Railroad Retirement Act which provide for cost adjustments between the two programs which place the social security trust funds in the position they would have been in if railroad employment had been covered under social security since 1937.

²⁶ App. F illustrates the improved protection resulting from a transfer-of-credit plan that follows this approach.

with the future development of provisions designed to improve the protection afforded such employees.

(e) Since this approach would not ordinarily have any effect upon the benefit status, under either program, of Federal employees who qualify for benefits under the civil service retirement system, it would not assure that a rational benefit related to the worker's lifetime record would be paid in all instances. This approach would, in fact, provide survivor protection (and in many cases, disability protection) for workers who have not completed 5 years of Federal employment that would be better than the survivor protection the workers would have at the point that they complete 5 years, and for some time thereafter.²⁷

Approach No. 6.—Provide for transfers of credit for Federal employment to social security, but only for employees who separate, die, or become disabled in Federal service with less than 5 years of work under the civil service retirement system.

Considerations

(a) This approach would fall short of the objective of filling the major gaps in the protection of those who move between Federal employment and other work. The major gaps in protection include gaps in retirement, survivors, and disability protection of the large numbers of workers who leave Federal employment after 5 or more years of service. Under this approach, none of these employees would carry social security protection with them when they leave Federal employment for other jobs.

(b) Because this approach would not deal with the problem of employees who are separated after 5 or more years of Federal service, it would involve somewhat less additional cost than approach No. 5.

(c) This approach would be even less effective than approach No. 5 in assuring payment of rational benefits related to a worker's lifetime earnings record in all instances. It would, moreover, give rise to an anomaly not involved in approach No. 5, in that the Federal employees who would not have social security protection upon separation would be those with the largest gaps in their social security coverage.

SUMMARY AND CONCLUSION

In summary, it appears to us that the principal advantages and disadvantages of the various approaches are as follows:

Approach No. 1 (employees covered under social security and the civil service retirement system, with no adjustment in the provisions of that system). Avoiding adjustment in the civil service retirement system provisions would be in accord with the views of employee organizations but the additional cost of this approach would be very high for employees and the Government. This approach would go beyond the objective of filling gaps in protection and would result in large increases in the benefits of many career employees; in some

²⁷ To illustrate, in the case of a young worker who works for 1 year under social security and 4 years under civil service retirement, averaging \$500 a month, and then dies, the widow and 1 child would receive social security survivor benefits of \$191 a month under the transfer-of-credit plan. If, however, the worker dies 1 year later, when he completes 5 years of Federal employment, the widow and child would receive \$71 a month from the civil service retirement system and would not be eligible for social security benefits. Under the railroad retirement-social security coordination (see footnote 25) this type of inequity is avoided through a provision guaranteeing a minimum benefit based on the social security benefit formula. To correct this situation would require changes in the civil service retirement system. (The operation of the railroad retirement-social security minimum provision if it were applied to the civil service retirement system is discussed in app. II.).

instances, retirement benefit amounts would exceed the employee's pay.

Approach No. 2 (same as approach No. 1 except that present and future employees could individually elect whether to come under social security). This approach has been favored by some employee organizations. The additional cost for the Government would not be quite as high as under approach No. 1 since some employees would not elect social security coverage. However, the additional Government cost would go toward providing high benefits for those employees who elected coverage—mainly the better paid employees who could readily afford to pay the social security employee contributions. Individual voluntary coverage under social security has always been considered undesirable because it involves adverse selection, which increases social security costs at the expense of those covered on a compulsory basis, and because some of those who have greatest need for social security protection would not elect coverage. Because some employees would not elect coverage, the objective of filling gaps in protection would not be fully achieved.

Approach No. 3 (employees covered under social security and the civil service retirement system, with adjustments in the retirement-system provisions to take account of social security coverage). A plan carrying out this approach would fill the gaps in protection and could be designed to accomplish this objective at substantially less cost than approaches No. 1 and No. 2. This approach more than others has the potential to assure that the combined benefits (and the combined contributions) of people who shift between work covered by social security and the civil service retirement system would be at a planned and systematic level. This approach would, however, require some increase in cost beyond that necessary to fill the gaps in protection. Past proposals which involved adjustments of provisions of the civil service retirement system to take account of social security coverage have been strongly opposed by organizations of Federal employees.

Approach No. 4 (same as approach No. 3 except that present employees could elect to come under the new combined coverage or to continue under present provisions of the civil service retirement system and not come under social security). The considerations applicable to approach No. 3 are also generally applicable to this approach. The option provided under approach No. 4 would meet objections of some present employees based on individual circumstances, but this approach has also been strongly opposed by organizations of Federal employees because of the changes which would be made in the provisions of the civil service retirement system for the long run.

Approach No. 5 (a transfer-of-credit plan broad enough to provide social security protection for workers with Federal employment who do not qualify for protection under the civil service retirement system). A transfer-of-credit approach would not be as effective as coverage-coordination plans in assuring a planned and systematic level of contributions and benefits for workers who shift between Federal employment and other work. However, approach No. 5 would achieve the objective of filling major gaps in the protection of workers with Federal employment without involving costs, such as would be involved in the coverage plans, for providing nonessential benefit

increases. Since this approach would not change the provisions of the civil service retirement system relative to career employees who stay in the Federal service, it would avoid objections which have been raised by employee organizations against plans which would make such changes.

Approach No. 6 (transfer of credits to social security in cases where employees die, become disabled, or separate before completing 5 years of Federal service). This approach would leave major gaps in protection unfilled, and would be even less effective than approach No. 5 in assuring a planned and systematic level of contributions and benefits for workers who shift between Federal employment and other work. It would, however, involve less additional cost than other approaches.

Conclusion

We have concluded that the transfer-of-credit approach, such as described under approach No. 5, is a workable and sound way of providing social security protection for Federal employees who do not qualify for benefits under the civil service retirement system. The transfer-of-credit plan which would follow approach No. 5 is described in appendix F. The plan would alleviate very serious problems which arise where no protection has been provided under the civil service retirement system. We believe that any arrangement that would fail to provide social security protection in the situations covered by this plan would fall short of being responsive in the minimum acceptable degree to the need of the workers for protection, and to the concern expressed by the Committee on Ways and Means when it requested the agencies to develop a way of dealing with the problem faced by persons with Federal employment. However, even this approach would not fill the gaps in survivorship and disability benefits for workers with 5 to 20 years of service or solve the problem involving workers who qualify for benefits under both social security and the civil service retirement system in total amounts which may be considered high in relation to the worker's lifetime earnings and contributions.

APPENDICES

- Appendix A. Principal provisions of the Civil Service Retirement Act.
 - Appendix B. Selected data on Federal civilian employment.
 - Appendix C. Illustrative monthly benefits payable under a fully additive plan.
 - Appendix D. A plan for extending social security coverage to Federal civilian employees who are covered by the civil service retirement system, and adjusting provisions of the retirement system to take account of social security coverage.
 - Appendix E. Recommendations of the Kaplan Committee for extension of OASDI coverage to employment covered by the Federal civil service retirement system.
 - Appendix F. A transfer-of-credit plan which follows approach No. 5.
 - Appendix G. Recommendation of the Advisory Council on Social Security concerning Federal employment.
 - Appendix H. Operation of the railroad retirement-social security minimum provision if applied to the civil service retirement system.
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APPENDIX A

PRINCIPAL PROVISIONS OF THE CIVIL SERVICE RETIREMENT ACT

A. TYPES OF BENEFITS

1. Age and service retirement benefit:
 - (a) Compulsory at or after age 70 with 15 years' service—full annuity terminating at death;
 - (b) Voluntary:
 - (i) At age 62 with 5 years' service—full annuity terminating at death;
 - (ii) At age 60 with 30 years' service—full annuity terminating at death;
 - (iii) At age 55 with 30 years' service—reduced annuity if under age 60, terminating at death;
 - (c) Involuntary (not for cause), at any age with 25 years' service or at age 50 or over with 20 years' service—reduced annuity if under age 60, terminating at death.

Cost-of-living increases first possible on the April 1 occurring 15 months or more after annuity begins.
2. Disability retirement benefit: At any age with 5 years' service, with finding of disability by Civil Service Commission—full annuity (special minimum) terminating at death or with recovery or restoration of earning capacity before age 60.

Cost-of-living increases first possible on the April 1 occurring 15 months or more after annuity begins.
3. Deferred retirement benefit: 5 or more years' service, refund not elected—full annuity at age 62, terminating at death.

Cost-of-living increases first possible on the April 1 occurring 15 months or more after annuity begins.
4. Lump-sum withdrawal: (a) Less than 5 years' service—refund of accumulated contributions; (b) 5 years' service, not eligible for immediate annuity—choice of refund or deferred retirement benefit.
5. Lump-sum benefit (death before retirement): No specified period of service, no survivor with annuity rights—refund of accumulated contributions.
6. Special lump-sum benefit (guaranteeing return of employee contributions): Payable if annuitant dies and no survivor has annuity rights or survivor annuities have terminated—refund of accumulated contributions less all annuity payments.

7. Survivor child benefit (death before retirement):

(a) With surviving parent and 5 years' service—benefit (terminating at death, marriage, or attainment of age 18 unless disabled, but continuing to attainment of age 21 for full-time students in recognized educational institutions) is the smallest of—

- (i) 40 percent of employee's "average salary," divided by number of children,
- (ii) \$1,800 divided by number of children,
- (iii) \$600.

Cost-of-living increases do not apply to the maximum defined in (i). Cost-of-living increases in maximums defined in (ii) and (iii) first possible on April 1, 1964, applying to computation of all future survivor child benefits at death of employee. After death of employee, further cost-of-living increases first possible on the April 1 occurring 15 months or more after annuity begins.

(b) With no surviving parent and 5 years' service—benefit under same conditions as in 7(a), except that benefit is the smallest of:

- (i) 50 percent of employee's "average salary" divided by number of children,
- (ii) \$2,160 divided by number of children,
- (iii) \$720.

Cost-of-living increases under same conditions as in 7(a).

8. Survivor child benefit (death after retirement):

(a) With surviving parent and 5 years' service—benefit (terminating at death, marriage, or attainment of age 18 unless disabled, but continuing to attainment of age 21 for full-time students in recognized educational institutions) is the smallest of—

- (i) 40 percent of employee's "average salary" divided by number of children,
- (ii) \$1,800 divided by number of children,
- (iii) \$600.

Cost-of-living increases in maximum defined in (i) first possible on the April 1 occurring 15 months or more after parent's annuity begins. Cost-of-living increases in maximums defined in (ii) and (iii) first possible April 1, 1964, applying to computation of all future survivor child benefits at death of employee annuitant. After death of employee annuitant, further cost-of-living increases, first possible on the April 1 occurring 15 months or more after child's annuity begins.

(b) With no surviving parent and 5 years' service—benefit under same conditions as in 8(a), except that benefit is the smallest of—

- (i) 50 percent of employee's "average salary" divided by number of children,
- (ii) \$2,160 divided by number of children,
- (iii) \$720.

Cost-of-living increases under same conditions as in 8(a).

9. Survivor spouse benefit (death before retirement), 5 years' service, payable to widow or disabled dependent widower—55 percent of regular service annuity, terminating at death or remarriage of widow or widower, or the widower's becoming capable of self-support.

Cost-of-living increases first possible on the April 1 occurring 15 months or more after annuity begins.

10. Elective survivor benefits (death after retirement):

(a) For married annuitant, payable to designated spouse—55 percent of amount designated by employee, terminating at death or remarriage of spouse;

(b) For unmarried annuitant (election not available for disability retirement), payable to designated person—55 percent of annuity, reduced for the election, terminating at death of beneficiary.

Cost-of-living increases first possible on the April 1 occurring 15 months or more after employee annuity begins. After death of employee annuitant, further increases first possible on the April 1 occurring 15 months or more after survivor annuity begins.

B. COMPUTATION OF BENEFIT AMOUNTS

1. "Average salary": Highest average annual basic salary during any 5 consecutive years.

2. Total service: Number of years plus full months expressed as fraction of year.

3. Basic annuity: The sum of—
 - (a) $1\frac{1}{2}$ percent of "average salary," or 1 percent of "average salary" plus \$25, whichever is greater, times first 5 years of service;
 - (b) $1\frac{1}{4}$ percent of "average salary," or 1 percent of "average salary" plus \$25, whichever is greater, times second 5 or less years of service;
 - (c) 2 percent of "average salary," or 1 percent of "average salary" plus \$25, whichever is greater, times service in excess of 10 years.
4. Maximum annuity: 80 percent of "average salary" but see item (1) under "Financing."
5. Minimum annuity (disability retirement only): The lesser of (a) 40 percent of "average salary," or (b) basic annuity computed using total actual service plus assumed additional service to age 60.
6. Reduction for retirement under age 60: No reduction for disability retirement. Otherwise, total annuity reduced by one-twelfth of 1 percent for each full month that the retiring employee is under age 60, except that if under age 55, reduction is 5 percent plus one-sixth of 1 percent for each full month that the employee is under age 55.
7. Reduction for unpaid deposits: Retiring employee fails to make full deposit due for noncontributory service; reduction in annuity (on an annual basis) is 10 percent of unpaid amount.
8. Optional reduction for survivor benefits:
 - (a) Married annuitant elects reduction for benefit of 55 percent of designated amount of annuity to wife or husband; reduction is $2\frac{1}{2}$ percent of the first \$3,600 of designated amount plus 10 percent of designated amount in excess of \$3,600. Election automatic (with designation of full amount of annuity) unless employee specifies otherwise.
 - (b) Unmarried annuitant elects reduction for benefit of 55 percent of reduced annuity to designated beneficiary; reduction is 10 percent of annuity plus 5 percent for each full 5 years the designated beneficiary is younger than the annuitant (total reduction not to exceed 40 percent). Option not available for those retiring for disability.

C. FINANCING

1. Employee contributions: $6\frac{1}{2}$ percent of basic salary; after employee has served long enough to earn maximum annuity of 80 percent of "average salary" (generally slightly less than 42 years), all future contributions, plus 3-percent interest, are at retirement applied toward deposits due for refunded or non-contributory service or treated as voluntary contributions, available for purchase of additional annuity or refund.
2. Agency contributions: $6\frac{1}{2}$ percent of basic salary.
3. Congressional appropriation: Civil Service Commission submits annual estimates of additional appropriations required.
4. Retirement fund investments: Principally invested in specially authorized U.S. issues; interest on current investments at a rate equal to the current average market yield on all outstanding U.S. marketable obligations not due or callable until after 4 years from such issuance. Current rate on new investments, $4\frac{1}{4}$ percent; current overall earning rate about $3\frac{1}{4}$ percent.

APPENDIX B

SELECTED DATA ON FEDERAL CIVILIAN EMPLOYMENT

TABLE 1.—*Mobility of Federal civilian employees as indicated by net accessions and separations, United States, 1955-64*¹

Fiscal year	Net accessions ²	Net separations ³	Fiscal year	Net accessions ²	Net separations ³
1955	475,000	419,000	1960	451,000	382,000
1956	437,000	372,000	1961	436,000	328,000
1957	458,000	381,000	1962	501,000	355,000
1958	464,000	370,000	1963	427,000	361,000
1959	397,000	340,000	1964	397,000	343,000

¹ Sources: Annual Report of U.S. Civil Service Commission, Federal Employment Statistics Bulletin, Graphic Presentation of Federal Employment, U.S. Civil Service Commission, Washington, D.C.

² Excludes transfers between agencies, and returns to duty from leave without pay and military service.

³ Excludes transfers between agencies, separations to enter military service, extended leaves without pay, and separations due to death, retirement, and disability.

TABLE 2.—*Length of Federal service of Federal employees under the civil service retirement system, June 30, 1963*¹

Length of service	Number of employees	Percent distribution
Total.....	2,300,000	100.0
Under 5 years.....	313,040	13.6
5 to 9 years.....	440,500	19.2
10 to 14 years.....	435,320	18.9
15 to 19 years.....	453,390	19.7
20 to 24 years.....	457,560	19.9
25 to 29 years.....	122,840	5.3
30 years and over.....	77,350	3.4

¹ Source: Federal Employment Statistics Bulletin. U.S. Civil Service Commission, November 1963. Employees have no protection under the civil service retirement system until they have completed 5 years of service.

TABLE 3.—*Withdrawal of contributions to civil service retirement system by employees separating from Federal employment after 5 or more years of service, by age and length of service*¹

Attained age in 1960	Total			Completed years of service ²								
	Num-ber	With-drawals	Per-cent	5 to 9			10 to 19			20 and over		
				Num-ber	With-drawals	Per-cent	Num-ber	With-drawals	Per-cent	Num-ber	With-drawals	Per-cent
Total.....	1,402	1,075	77	1,016	822	81	361	244	68	25	9	36
20 to 29.....	160	141	88	158	140	89	2	1	50			
30 to 39.....	555	476	86	412	360	87	142	115	81	1	1	100
40 to 49.....	421	396	73	281	213	76	127	87	68	13	6	46
50 to 59.....	233	136	58	143	99	69	80	35	44	10	2	20
Over 59.....	33	16	48	22	10	45	10	6	60	1	0	0

¹ Source: Characteristics of Persons Separating and Withdrawing Contributions From the Federal Civil Service Retirement System. Analytical Note No. 6-61 prepared by Joseph Krislov, Social Security Administration, June 1961. Employees who separate after 5 or more years of service and withdraw their contributions thereby forfeit rights to a deferred annuity at age 62. (Employees who separate after less than 5 years of service are eligible only for a refund of their contributions.)

² Individual's Federal civilian service, unbroken by any refunds, for 1,182 persons, and individual's total Federal civilian service, including years for which refunds were paid, for 220 persons. Data include only withdrawals of contributions taken within 1st 6 months following separation.

APPENDIX C

ILLUSTRATIVE MONTHLY BENEFITS PAYABLE UNDER A FULLY ADDITIVE PLAN

Retirement benefits to retired worker and wife ¹

Monthly pay ²	A. Work history—40 years, all in Federal service		B. Work history—32 years Federal, 8 years non-Federal service		C. Work history—25 years Federal, 15 years non-Federal service		D. Work history—15 years Federal, 25 years non-Federal service	
	Present law	Fully additive	Present law	Fully additive	Present law	Fully additive	Present law	Fully additive
\$333 (\$4,000 per annum):								
CSR.....	\$250	\$250	\$198	\$198	\$152	\$152	\$87	\$87
OASDI:								
Worker.....	0	112	0	112	69	112	88	112
Wife.....	0	56	0	56	35	56	44	56
Total.....	250	418	198	366	256	320	219	255
\$500 (\$6,000 per annum):								
CSR.....	366	366	294	294	225	225	128	128
OASDI:								
Worker.....	0	127	0	127	75	127	97	127
Wife.....	0	64	0	64	38	64	49	64
Total.....	366	557	294	485	338	416	274	319
\$833 (\$10,000 per annum):								
CSR.....	594	594	474	474	369	369	213	213
OASDI:								
Worker.....	0	127	0	127	75	127	97	127
Wife.....	0	64	0	64	38	64	49	64
Total.....	594	785	474	665	482	560	359	404

¹ Assumes employee and wife are both aged 65 when he retires, and that employee elects reduced CSR annuity to provide CSR survivor protection for wife. An employee who does not elect this reduction would of course receive somewhat higher benefits than those indicated above for the retired worker, both under present law and under coordination.

² Average pay during 5 highest earnings years in Federal service. Average earnings under OASDI are assumed to be these amounts or \$400 per month (\$4,800 per annum) whichever is less. All employment occurs after effective date of plan.

SURVIVORS BENEFITS—FULLY ADDITIVE PLAN

Illustrative monthly benefits payable to a widow with two minor children of a worker who dies while in Federal employment, after 10 years of Federal service. His "high-5-year average pay" is \$6,000; his average annual earnings for OASDI purposes is \$4,800.

	System paying benefits	Present law	Fully additive plan
Widow with 2 minor children ¹	CSR.....	\$145	\$145
	OASDI.....	0	254
Total.....		145	399

¹ Child's benefits under OASDI terminate when the child reaches age 18. Benefits to a widow under age 62 terminate when there are no longer any children of the worker under age 18. Child's benefits under CSR terminate generally at age 18, unless the child is a student, in which case benefits continue up to age 21. Widow's benefits under CSR are payable regardless of the age of the widow or whether or not there are still children of the worker under age 21.

Illustrative monthly benefits payable to a widow with no minor children of a worker who dies in Federal employment, after 25 years of Federal service. His "high-5-year average pay" is \$6,000; his average annual earnings for OASDI purposes is \$4,800.

	System paying benefits	Present law	Fully additive plan
Widow over age 62.....	CSR..... OASDI.....	\$127 0	\$127 105
Total.....		127	232

APPENDIX D

A PLAN FOR EXTENDING SOCIAL SECURITY COVERAGE TO FEDERAL CIVILIAN EMPLOYEES WHO ARE COVERED BY THE CIVIL SERVICE RETIREMENT SYSTEM, AND ADJUSTING PROVISIONS OF THE RETIREMENT SYSTEM TO TAKE ACCOUNT OF SOCIAL SECURITY COVERAGE

SUMMARY OF PROVISIONS OF COORDINATION PLAN

Employees who are subject to civil service retirement contributions before January 1, 1966, would have an option to remain under civil service retirement only or to elect coverage under both CSR and OASDI. Employees who become subject to CSR contributions on or after January 1, 1966, would be covered under both OASDI and CSR. When both an OASDI benefit and a CSR annuity are payable, the CSR annuity would be reduced under a formula which takes into account the employee's length of Federal service under the coordination plan; the reduction formula would not provide any reduction for the period during which the employee was covered only by the CSR system, or for any OASDI covered employment for non-Federal service.

Giving a choice of coverage to present employees is comparable to the so-called "divided retirement system" provision which has been used in extending coverage to many State and local government employees who are members of retirement systems. The requirement that all employees hired in the future must be covered under OASDI limits adverse selection to current employees. Giving a choice to current employees seems justified when the choice is between one type of coverage or another, and not between coverage or no coverage.

SPECIFIC PROVISIONS

1. OASDI coverage

(a) Employees subject to CSR contributions on December 31, 1965, would make a one-time irrevocable election to (1) stay under CSR only, or (2) come under the coordination plan with coverage under both CSR and OASDI. In general, present employees would make their elections on a specified election date prior to January 1, 1966; however, special provision would be made to afford newly hired employees a reasonable period of time to consider the plan before making an election.

(b) Six quarters of retroactive OASDI coverage would be extended to all employees who elect to come under the plan and who have been continuously subject to CSR since June 30, 1964. Appropriate FICA tax payments for the retroactive coverage would be made by the employee and by the Government, accomplished through a transfer from the CSR fund. Less than six quarters of retroactive coverage would be extended to employees not in Federal service subject to CSR for the whole retroactive period. A currently insured OASDI status would exist from the effective date of the coordination plan for employees who elect to come under the plan and who receive the full six quarters of retroactive coverage.

(c) New employees (those entering Federal service on or after January 1, 1966) would be covered under OASDI from the beginning date of their employment. Persons employed prior to December 31, 1965, who reenter Federal employment after a break in service that includes that date would be covered under OASDI from the beginning date of their reemployment after December 31, 1965.

(d) The coordination plan would not propose extension of OASDI coverage to Members of Congress and congressional employees.

(e) Categories of Federal civilian employees now excluded from CSR coverage and covered only under OASDI would continue to be covered only under OASDI.

2. *CSR coverage*

(a) Present coverage provisions as they apply to new employees would be retained. Temporary and intermittent employees would continue to be excluded.

(b) Employees subject to CSR contributions on December 31, 1965, could, as indicated in item 1(a), elect to remain under the present provisions of the CSR system, or to be covered under both CSR and OASDI.

3. *Contributions*

(a) *OASDI*.—Social security (FICA) contributions would be at the rates scheduled in the law, on basic salary up to \$4,800. Thus, employees and the employing agency would each contribute $4\frac{1}{8}$ percent for 1966–67, and $4\frac{5}{8}$ percent for 1968 and thereafter. The maximum annual cost would be \$222 for the employee, matched by \$222 for the employer. Retroactive contributions for 6 quarters retroactive coverage would be made on the basis of the $3\frac{3}{8}$ percent rate for 1965 and 1964. The maximum retroactive contributions would be \$261 each for employer and employee.

(b) *CSR*.—An employee who is subject to both CSR and OASDI would contribute to the CSR fund $6\frac{1}{2}$ percent of his basic salary over \$4,800 and a smaller percentage of his basic salary up to \$4,800. Agency “matching” contributions would be made on a similar basis. An employee who is subject only to CSR would continue to contribute $6\frac{1}{2}$ percent of all basic salary, with equivalent agency matching contributions.

4. *Benefits payable*

(a) All OASDI benefits would be payable as under present law, including, where applicable, old-age benefits, wives’ benefits, disability benefits, and survivor benefits for widows, dependent widowers, children, and dependent parents.

(b) *Conditions for reduction of CSR annuity*.—A retirement, disability, or survivor annuity under CSR would be reduced only if: (1) The person receiving the annuity becomes entitled to an OASDI benefit (or would, upon application, become entitled to an OASDI benefit that is not actuarially reduced) based on the employee’s OASDI earnings record for Federal service under the coordinated plan; and (2) the employee’s Federal service covered under OASDI would be sufficient to give him OASDI insured status, based on the provisions of the Social Security Act in effect on January 1, 1966. (Subsequent liberalizations of OASDI insured status would not be considered in determining whether the annuity is to be reduced.)

(c) *Amount of reduction in age and service retirement annuity*.—Several proposed reduction formulas were considered. Each of them would provide an annual reduction of the employee’s annuity based on the number of years of dual coverage, up to a specified maximum number of such years. The reduction under the formula considered most feasible is as follows:

One percent of “high-5” average (or, if less, \$48) multiplied by years of Federal service after December 31, 1965,¹ not in excess of 30.

The formula would apply directly in the case of persons receiving unreduced OASI benefits. If a person is entitled to actuarially reduced OASI benefits the reduction in his CSR annuity would be somewhat smaller. In such a case, the amount by which the CSR annuity is reduced would be adjusted downward by the same percentage as the OASI benefit is reduced. The present maximum benefit provision of CSR (80 percent of high-5 year average salary) would be applied before an annuity is reduced to take OASDI benefits into account.

(d) *Reduction of disability annuity*.—Provided the disabled employee is eligible for social security disability benefits, a disability annuity that is computed without resorting to the CSR minimum guarantee² would be reduced in the same manner as age and service retirement annuities. The reduction of a disability annuity computed under the minimum guarantee provisions would be based not on the employee’s actual service but on the total service he would have needed to “earn” the disability minimum annuity if the normal CSR retirement formula had applied instead. Any years of coverage under CSR only would be deducted from this total. The result would be entered as “Federal service after December 31, 1965” in the formula for computing the CSR annuity reduction.

¹ Plus a maximum of $1\frac{1}{2}$ years of retroactive coverage.

² The minimum disability annuity provided under CSR is the lesser of (a) 40 percent of the “high-5” average salary, or (b) an annuity computed under the basic annuity formula using the actual service plus assumed additional service to age 60. However, an employee is not eligible for disability protection under CSR until he has completed 5 years of civilian service.

If the disabled employee is not eligible for social security disability benefits, no reduction would apply. If he later becomes eligible for an old-age benefit under OASDI, his CSR annuity would then be reduced, using only actual Federal service after December 31, 1965, in the reduction formula.

(e) *Reduction of survivor spouse annuity (death before retirement).*—The annuity payable to the widow or dependent widower would be 55 percent of the employee's reduced annuity rather than 55 percent of the employee's full annuity. The employee's reduced annuity (on which the survivor annuity is based) would be computed in the same way as the annuity of a retired employee eligible for OASDI benefits.

(f) *Reduction of survivor annuity elected for spouse or for person with insurable interest in life of employee (death after retirement).*³—If the retired employee designated the full amount of his annuity as the basis of the survivor annuity, the reduction in the survivor annuity would be the same as in the case of death before retirement. If the retired employee designated only part of his annuity, the reduction of the survivor annuity would be proportional to the reduction that would apply in the case of a survivor annuity based on the employee's full annuity.

(g) *Elimination of survivor child annuities where OASDI benefits are payable.*—The CSR survivor child annuity would be eliminated in every case in which the employee was subject to dual coverage under OASDI and CSR.

(h) *Coordination plan guarantee.*—The plan would include a guarantee applicable only to present employees and their survivors, that the OASDI benefit and the CSR annuity together would be at least as great as the CSR annuity which would have been payable had the employee not elected dual coverage. The guarantee would, of course, apply only if the individual eligible for OASDI benefits files application for them; the guaranteed amount would be determined on the basis of OASDI benefits payable without regard to the retirement test.

*Illustrative monthly retirement benefits to single retired worker under the coverage-coordination plan*¹

Monthly pay ²	A. Work history—40 years, all in Federal service		B. Work history—32 years Federal, 8 years non-Federal service		C. Work history—25 years Federal, 15 years non-Federal service		D. Work history—15 years Federal, 25 years non-Federal service	
	Present law	Coordination	Present law	Coordination	Present law	Coordination	Present law	Coordination
\$333 (\$4,000 per annum):								
CSR.....	\$256	\$156	\$202	\$102	\$156	\$73	\$89	\$39
OASDI.....	0	112	0	112	69	112	88	112
Total.....	256	268	202	214	225	185	177	151
\$500 (\$6,000 per annum):								
CSR.....	381	261	301	191	231	131	131	71
OASDI.....	0	127	0	127	75	127	97	127
Total.....	381	388	301	308	306	258	228	198
\$833 (\$10,000 per annum):								
CSR.....	635	515	502	382	385	285	219	159
OASDI.....	0	127	0	127	75	127	97	127
Total.....	635	642	502	509	460	412	316	286

¹ Assumes employee is aged 65 when he retires.

² Average pay during 5 highest earnings years in Federal service. Average earnings under OASDI are assumed to be these amounts or \$400 per month (\$4,800 per annum), whichever is less. All employment occurs after effective date of plan.

³ Under CSR, the reduction in the employee's annuity is 2½ percent of the first \$3,600 of the amount designated plus 10 percent of the designated amount in excess of \$3,600. As now provided under CSR, the election of a survivor annuity of a spouse is automatic and the full amount of the retirement annuity is designated unless the employee specifies otherwise.

Illustrative monthly retirement benefits to retired worker and wife under the coverage-coordination plan ¹

Monthly pay ²	A. Work history—40 years, all in Federal service		B. Work history—32 years Federal, 8 years non-Federal service		C. Work history—25 years Federal, 15 years non-Federal service		D. Work history—16 years Federal, 25 years non-Federal service	
	Present law	Coordination	Present law	Coordination	Present law	Coordination	Present law	Coordination
\$233 \$4,000 per annum:								
CSR.....	\$150	\$152	\$195	\$100	\$152	\$71	\$57	\$39
OASDI:								
Worker.....	0	112	0	112	69	112	55	112
Wife.....	0	56	0	56	35	56	44	56
Total.....	250	320	195	268	256	239	219	207
\$500 \$8,000 per annum:								
CSR.....	306	255	294	177	225	128	128	69
OASDI:								
Worker.....	0	127	0	127	75	127	97	127
Wife.....	0	64	0	64	38	64	49	64
Total.....	306	446	294	368	338	319	274	260
\$833 \$13,000 per annum:								
CSR.....	594	486	474	368	369	278	213	155
OASDI:								
Worker.....	0	127	0	127	75	127	97	127
Wife.....	0	64	0	64	38	64	49	64
Total.....	594	677	474	557	482	469	359	346

¹ Assumes employee and wife are both aged 65 when he retires, and that employee elects reduced CSR annuity to provide CSR survivor protection for wife. An employee who does not elect this reduction would of course, receive somewhat higher benefits than those indicated above for the retired worker, both under present law and under coordination.

² Average pay during 5 highest earnings years in Federal service. Average earnings under OASDI are assumed to be these amounts or \$400 per month (\$4,800 per annum), whichever is less. All employment occurs after effective date of plan.

SURVIVORS BENEFITS—COORDINATION PLAN

Illustrative monthly benefits payable to a widow with two minor children ⁴ of a worker who dies while in Federal employment, after 10 years of Federal service. His "high-5-year average pay" is \$6,000; his average annual earnings for OASDI purposes is \$4,800.

	System paying benefits	Present law	Coordination plan
While there are 2 minor children.....	CSR.....	\$145	\$23
	OASDI.....	0	254
Total.....		145	277
While there is 1 minor child.....	CSR.....	95	23
	OASDI.....	0	191
Total.....		95	214
While there are no minor children, widow under age 62.....	CSR.....	45	45
	OASDI.....	0	0
Total.....		45	45

Illustrative monthly benefits payable to a widow, after she reaches 62, of a worker who dies in Federal employment, after 25 years of Federal service. His

⁴ Child's benefits under social security terminate when the child reaches age 18. Benefits to a widow under age 62 terminate when there are no longer any children of the worker under age 18. Child's benefits under CSR terminate generally at age 18, unless the child is a student, in which case benefits continue up to age 21. Widow's benefits under CSR are payable regardless of the age of the widow or whether or not there are still children of the worker under age 21.

"high-5-year average pay" is \$6,000; his average annual earnings for OASDI purposes is \$4,800.

System paying benefits	Present law	Coordination plan
CSR.....	\$127	¹ \$72
OASDI.....	0	105
Total.....	127	177

¹ Widow's benefits under civil service retirement begin when the employee dies, regardless of the age of the widow. There would be no reduction of such benefits for periods when there is no eligibility for OASDI benefits.

APPENDIX E

RECOMMENDATIONS OF THE KAPLAN COMMITTEE⁵ FOR EXTENSION OF SOCIAL SECURITY COVERAGE TO EMPLOYMENT COVERED BY THE FEDERAL CIVIL SERVICE RETIREMENT SYSTEM

The plan for extending social security coverage to employment covered by the civil service retirement system which was recommended by the Kaplan Committee in 1954 must of course be considered in light of the provisions of the CSR and OASI programs at that time. Major changes in the two programs since 1954 have made a number of specific recommendations of the Kaplan Committee obsolete.

The more important changes have been made in the CSR provisions (by legislation enacted in 1956 and 1962)⁶ are: (a) increase in the basic annuity formula from 1½ percent of high-5-year average pay for each year of service to 1½ percent for each of the first 5 years of service, 1¾ percent for each of the next 5 years, and 2 percent for each year of service after the 10th; (b) provision of a guarantee (generally speaking) of 40 percent of high-5-year average pay for employees qualifying for disability annuities; (c) improvement of survivor annuities; (d) provision for automatic cost-of-living increases for annuitants; and (e) increase in the employee contribution rate to 6½ percent of pay, compared with 6 percent in 1954. In 1954, the cost of the CSR system was estimated at 15.70 percent of payroll—11.15 percent was the normal cost and 4.55 percent was a deficiency arising from past costs for which no contributions were obtained (known as the unfunded accrued liability). The present estimate of the cost of the system is 22.33 percent of payroll—13.49 percent normal cost and 8.84 percent deficiency cost.

The committee's recommendations contemplated the enactment of the 1954 social security amendments, then under consideration in the Congress, but, of course, did not anticipate the subsequent changes. Among the changes made in social security after the enactment of the 1954 amendments are: (a) increase in social security benefit levels through a change in the benefit formula as well as an increase in the amount of covered earnings to \$4,800 from \$4,200; (b) lowering the requirements for fully insured status; (c) addition of disability insurance benefits; (d) easing of the retirement test; (e) provision for benefits at age 62 (generally on an actuarially reduced basis); and (f) increase in the ultimate employee and employer contribution rate from 4 percent each reached in 1975 to 4½ percent each reached in 1968.

Following the 1954 amendments, the level-premium cost of the social security program was estimated on an intermediate cost basis as 7.45 percent of taxable payroll. The cost of the present program is estimated at 9.33 percent of taxable payroll. Among other things which have helped to outdate the 1954 recommendations are the greatly increased period of time elapsing since the social security "new start" (Jan. 1, 1951) for computing benefit amounts and insured status.

⁵ The Committee on Retirement Policy for Federal Personnel, established pursuant to Public Law 555 82d Cong., to make a comparative study of retirement systems for Federal personnel and to report to the Congress its findings and recommendations. The Committee consisted of high officials of the executive branch of the Government with the exception of the Chairman, H. Eliot Kaplan. Its report was submitted May 20, 1954.

⁶ Public Law 854, approved July 31, 1956, and Public Law 87-793, approved Oct. 11 1962.

The following example, based on the case of an employee retiring at age 65 after 30 years of Federal service with \$6,000 salary, illustrates the effects of some of the changes made since 1954.

	Employee's monthly benefit	Wife's benefit
1954 CSR law	\$225	0
1954 Kaplan plan, CSR and OASI	245	\$42
1958 CSR law	281	0
1958 CSR and OASDI, if CSR were reduced by same percentage of pay as under Kaplan plan	319	50

General recommendations of the Kaplan plan.—All active members of the CSR system (except Congressmen and congressional employees) would have been covered by both CSR and OASI effective January 1, 1956.

The adjusted CSR formula,⁷ to be applied in all cases where an OASI benefit based on Federal service was also payable, would have been: 1 percent of the first \$5,000 of high-5-year average pay plus 1½ percent of such pay in excess of \$5,000, multiplied by years of service. In this connection, two points should be noted: (a) the \$5,000 figure was recommended despite the fact that the anticipated OASI earnings base was \$4,200, and (b) in cases where the proposed formula was applicable, it was intended to be applied to all years of service, including service prior to the effective date of the plan.

The proposed change in the CSR annuity formula would not have affected anyone who retired or otherwise terminated his Federal service before January 1, 1956. Only those who completed enough Federal civilian service covered by OASI to be "insured" for OASI benefits were to be subject to the new CSR annuity formula. (At the time, to be fully insured under OASI a worker was required to have half as many quarters of coverage as the number of calendar quarters elapsing after 1950 (or age 21, if later) and before age 65, with a minimum of 6 quarters of coverage.)

Under the proposed plan, the minimum number of years of service for eligibility under CSR for survivor protection or for a deferred retirement annuity would have been increased (from 5 years of service) to 10 years of service.

The proposed plan included a guarantee that the total benefit based on Federal service (i.e., the reduced CSR annuity plus the social security benefit based on Federal service) would in no case be less than the benefit which would have been payable by the CSR system under provisions then in effect.

Age and service retirement annuity.—No change was proposed in the computation of retirement annuities payable prior to age 65. The modified CSR formula, mentioned earlier, would have been applicable in respect to all such annuity amounts payable at or after age 65 if the annuitant was insured under OASI on the basis of his Federal service.

Following are illustrative monthly retirement benefits, payable after age 65 under the CSR formula as existing in 1954 and as proposed by the Kaplan Committee. Where high-5-year average pay was in excess of \$4,800, the increase in benefits under the plan would have been in the same absolute dollar amounts as in the \$4,800 case.

High-5-year average pay	20 years' service			30 years' service		
	Existing	Proposed		Existing	Proposed	
		Worker	Wife		Worker	Wife
\$4,200	\$112	\$123	\$27	\$165	\$155	\$40
\$4,800	122	135	28	183	203	42

As indicated, no benefit was (nor is now) provided under CSR for the wife of a retired employee. Under the proposed plan, the social security benefits for a wife (or dependent husband) would have been available when the wife attained age 65.

⁷ As noted, in 1954 the basic CSR benefit formula for computing retirement disability, and (indirectly) survivor annuities was: 1½ percent of high-5-year average pay, multiplied by the employee's years of service. The CSR law provided a more favorable formula for computing annuities of employees high-5-year average earnings were below \$5,000 per year. The 1954 recommendation included a proposed method, not discussed here, of providing equitable adjustments in CSR benefits computed under the alternative formula.

It was estimated that under the plan retirement benefit amounts based on Federal employment would be increased, on the average, by about 8 percent after age 65. The percentage increase would have been smaller, of course, for employees in the higher salary range. However, the combined benefits for a retired employee and his wife after both reached age 65 would have exceeded the existing CSR benefit by as much as 30 percent for those with low salary bases, and by 20 percent for those with a high-5-year average of \$8,000.

Disability retirement.—Inasmuch as disability insurance benefits had not been provided under social security by 1954, no changes in the CSR disability provisions were recommended in connection with the coordination plan.

Survivor protection.—Among the principal changes recommended were (a) the widow's CSR annuity amount was to be half of the retirement annuity, computed under the new formula instead of the existing formula, earned by the employee up to the time of death; (b) elimination of the CSR annuities for surviving children; (c) making the widow's CSR annuity payable immediately (instead of at age 50) when no children survived; and (d) upon election by a retired employee of a reduced annuity to provide a survivor annuity in case of his death, the reduction would be on an actuarial basis, resulting in a greater reduction than under the provisions then in effect.

Despite the proposed cutbacks in survivor protection provided under CSR, the net result of these changes and the addition of social security survivor benefits would have been a very substantial improvement in the survivor protection of Federal workers.

Period of transition.—Several special provisions were proposed—principally a guarantee of social security survivor protection—to be effective temporarily in the period after the coordination plan was adopted to make it fully effective without delay.

Employee contributions.—The then existing employee contribution rate under CSR of 6 percent would have been continued for that part of an employee's salary in excess of \$4,200 a year (the OASI earnings base) and would have been reduced to 3½ percent with respect to salary of \$4,200 or less. In addition the employee (and the Government, as employer) would have paid social security contributions—then 2 percent of the first \$4,200 of pay, and scheduled to rise, ultimately, to 4 percent.

Cost effects.—It was estimated that after 1954 under the proposed plan, the reduce "normal" cost (average cost for new entrants) of the CSR system plus employer and employee social security contributions would reach an amount about 3½ percent of payroll in excess of the 1954 normal cost of CSR. The "unfunded accrued liability" of the CSR system (estimated by the CSR Board of Actuaries to be 4.55 percent of payroll as of June 30, 1954) would, however, have been reduced by about one-third so that the net added cost was estimated at about 2 percent of payroll. Some savings would also have accrued to the OASI system (the saving was estimated in 1954 at about 0.05 percent of covered payroll) by reason of the broadening of social security coverage proposed under the plan.

Administration proposal.—The Administration approved the coordination plan and, in January 1956, the Civil Service Commission transmitted to Congress proposed legislation that substantially embodied recommendations of the Kaplan Committee for extending OASI coverage to employment covered by the CSR system. However, the bill (S. 3041), introduced January 25, 1956, by Senator Frank Carlson, ranking minority (Republican) member of the Senate Post Office and Civil Service Committee, was not reported out.

APPENDIX F

A TRANSFER-OF-CREDIT PLAN WHICH FOLLOWS APPROACH No. 5

Credit would be transferred from the civil service retirement system to social security for the Federal service of—

(1) People who die, become disabled, or separate from work covered under the civil service retirement system after less than 5 years of Federal service. Example: Worker becomes totally disabled or dies after working one year in work covered by social security and then 4 years under civil service retirement. Under present law no monthly benefits would be payable under civil service retirement or social security. Under the transfer-of-credit plan, if he were disabled he would get monthly social security benefits of \$127, and if he

has a wife and child, the family would get benefits of \$254; if he died his widow and child would get a monthly social security benefit of \$191.⁸

(2) People who separate after 5 or more years of Federal work and obtain refunds of their contributions to the civil service retirement system. Example: Worker has 6 years of employment under the civil service retirement system, and separates, taking a refund of civil service retirement contributions. He then works one year under social security, and then dies. Under present law, no monthly benefits would be payable under civil service retirement or social security to his widow and two children. Under the transfer-of-credit plan, monthly social security benefits of \$254 would be payable to the surviving family.⁸

(3) People who separate after 5 or more years of Federal work and do not take refunds of their contributions to the civil service retirement system, if such persons die before age 62. As in the preceding example, under present law no monthly benefits would be payable under civil service retirement or social security to the worker's widow and two children; under the transfer-of-credit plan, monthly social security benefits of \$254 would be payable to the surviving family.⁸

The transfer-of-credit plan would be applicable to Federal employment performed on or after a specified future date, such as the first day of the year following the enactment of legislation. For those in Federal employment on the effective date the plan would also be applicable to employment during the preceding 1½ year period, thus assuring immediate survivor protection for the families of such workers.

COSTS

The costs of this transfer-of-credit plan has been estimated on the assumption that the cost of the benefits resulting from the plan would be roughly equivalent to the value of employer and employee social security contributions on earnings for which credit would be transferred—that is, the contributions which would be payable if such earnings were covered under social security instead of the civil service retirement system when the work was performed. On this basis, the long-run cost of the plan for the Government, as employer, would be about \$75 million annually, or about one-half of 1 percent of payroll.⁹

About half of the cost of the plan would be borne by those workers who would have credit for their Federal employment transferred to social security under the plan—those who separate from Federal service and receive refunds of their contributions to the civil service retirement system, or who die or become disabled while employed but before completing 5 years of Federal service. In all such cases, the civil service retirement system would deduct from the refunds an amount equal to the social security contributions which the worker would have been required to pay if his Federal employment had been covered under social security. The additional protection which the plan would provide for career employees during their early years of Federal service—social security credit for survivorship and disability protection during the first 5 years of service—would be provided without additional cost to them.

Appropriate arrangements would be developed by the agencies concerned for the transfer to the social security trust funds of amounts sufficient to meet the proportionate cost, attributable to Federal employment, of social security benefits which would be paid as a result of the transfer-of-credit plan. The proportion of the cost attributable to Federal employment would be the ratio that the dollar amount of a worker's transferred credits bears to his total social security earnings credits after the transfer.

CHARTS SHOWING BENEFIT AMOUNTS PAYABLE IN ILLUSTRATIVE CASES UNDER PRESENT LAW, AND UNDER A TRANSFER-OF-CREDIT PLAN¹⁰

The charts on the following pages illustrate the effect of the transfer-of-credit plan in cases involving various combinations of work under social security and the civil service retirement system (referred to as OASDI and CSR, respectively, in the charts).

⁸ Computations are based on assumed earnings of \$4,800 a year in civil service retirement or social security work.

⁹ This estimate is of course based on present social security law, providing for social security employer and employee contributions on the first \$4,800 of an employee's annual covered earnings. Contributions rates for employer and employee are 3½ percent each for 1964-65, 4½ percent for 1966-67, and 4½ percent for 1968 and after.

¹⁰ The transfer-of-credit plan which is described on pp. 28 and 29 of this appendix.

In all cases, it is assumed that the plan has been in operation over the entire work lifetime of the individual, and that he earns at least \$4,800 each year (the maximum amount creditable under social security under present law). It is also assumed that the individuals begin working at age 22, with the exception of case G, in which a female worker begins employment at age 18.

In none of the cases would monthly benefits be payable under the civil service retirement system; if such benefits were payable, the transfer-of-credit plan would not apply. In all cases the employee's contributions (including interest, if Federal service was less than 5 years) to the civil service retirement system are refunded, either to the separated employee or the survivors of the deceased employee or former employee. Under the transfer-of-credit plan, the amount refunded would be reduced by an amount equal to the social security contributions the employee would have paid if his Federal employment had been covered under social security.

The following social security benefits are payable to insured workers, their dependents, and survivors. Survivors monthly benefits are payable to a widow (or dependent divorced wife) who is caring for the worker's child entitled to benefits, to a dependent child, and, at age 62, to a widow, dependent widower, or dependent parent. A lump-sum death payment is also made. Disability monthly benefits are payable to a worker, to his dependent child, and to his wife if she is caring for a child beneficiary or if she has reached age 62. Retirement monthly benefits are payable to a retired worker, his wife (or dependent husband) at age 62, a dependent child, and a wife who has not reached age 62 if she is caring for a child beneficiary. A worker may elect to have his social security retirement benefits begin as early as age 62, but the amount of the monthly benefit is reduced according to the number of months that the benefit will be paid before the worker reaches age 65. A worker receiving disability benefits is transferred to the old-age insurance beneficiary roll (with the same benefit amount) at age 65. Social security benefits of persons who have not reached age 72 and who earn more than \$1,200 in a year are reduced by \$1 for each \$2 earned from \$1,200 to \$1,700, and by \$1 for each \$1 of earnings over \$1,700.

Case A

Mr. A works 1 year under OASDI. He then works 4 years under CSR when it is assumed that he (1) becomes disabled, or (2) dies.

	System paying benefits	Monthly disability benefits		Monthly survivor benefits, widow and 1 child
		Worker alone	Worker, wife and 1 child	
Present law.....	CSR.....	1 0	1 0	1 0
	OASDI.....	0	0	0
Transfer-of-credit plan.....	CSR.....	2 0	2 0	2 0
	OASDI.....	\$127	\$254	\$191

¹ No annuity benefit. Lump-sum refund of employee's CSR contributions plus interest.

² No annuity benefit. Reduced lump-sum refund (employees' CSR contributions plus interest, reduced for employee OASDI taxes).

Case B

Mr. B works 2 years under CSR. He then separates from his Government job because of a severe disability and dies before he attains age 30.

	System paying benefits	Monthly disability benefits		Monthly survivor benefits, widow and 1 child
		Worker alone	Worker, wife and 1 child	
Present law.....	CSR.....	1 0	1 0	1 0
	OASDI.....	0	0	0
Transfer-of-credit plan.....	CSR.....	2 0	2 0	2 0
	OASDI.....	0	0	³ \$191

¹ No annuity benefit. Lump-sum refund of employee's CSR contributions plus interest.

² No annuity benefit. Reduced lump-sum refund (employee's CSR contributions plus interest, reduced for employee OASDI taxes).

³ Based on his 8 quarters of coverage, the worker also has OASDI survivorship protection in his 30th year, but for a smaller benefit amount (\$147 for a widow and 1 child) but he is not insured if he dies at age 31 or later.

Case C

Mr. C works 12 years under CSR. He then separates from his Government job, taking a refund of his contributions, and works 12 years under OASDI, when it is assumed that he (1) becomes disabled, or (2) dies.

	System paying benefits	Monthly disability benefits		Monthly survivor benefits, widow and 2 children
		Worker alone	Worker, wife, and 2 children	
Present law.....	CSR.....	10	10	10
	OASDI.....	\$86	\$24	\$23
Transfer-of-credit plan.....	CSR.....	10	10	10
	OASDI.....	127	254	254

¹ No annuity benefit. Lump-sum refund of employees' CSR contributions, without interest.

² No annuity benefit. Reduced lump-sum refund (employee's CSR contributions without interest, reduced for employee OASDI taxes).

NOTE.—80 percent of male workers with 10 to 19 years of Federal service unbroken by any refund of CSR contributions who separate between the ages of 30 to 39 years claim a CSR refund within 6 months of separation.

Source: Social Security Administration Analytical Note No. 6-61.

Case D

Mr. D works 12 years under CSR. He then separates from his Government job, not taking a refund of his contributions, and works 12 years under OASDI, when it is assumed that he (1) becomes disabled, or (2) dies. (Identical to case C except no refund.)

	System paying benefits	Monthly disability benefits		Monthly survivor benefits, widow and 2 children
		Worker alone	Worker, wife, and 2 children	
Present law.....	CSR.....	10	10	10
	OASDI.....	\$86	\$24	\$23
Transfer-of-credit plan.....	CSR.....	10	10	10
	OASDI.....	96	208	254

¹ If no refund is elected before age 62, worker is entitled to monthly CSR benefit of \$81 if he attains that age.

² Survivor receives lump-sum refund of employee's CSR contributions, without interest.

³ Same benefit as in footnote 1, but if, before age 62, a reduced lump-sum refund is elected (forfeiting CSR benefit at age 62), OASDI benefit becomes \$127 (worker alone) or \$254 (worker and family).

⁴ Survivor receives reduced lump-sum refund (employee's CSR contributions without interest, reduced for employee OASDI taxes).

Case E

Mrs. E works 12 years under CSR. She then separates from her Government job to become a housewife and takes a refund of her contributions.

	System paying benefits	Monthly disability benefits		Monthly retirement benefits, at age 62
		Disabled 0 to 5 years after separation	Disabled more than 5 years after separation	
Present law.....	CSR.....	10	10	10
	OASDI.....	0	0	0
Transfer-of-credit plan.....	CSR.....	10	10	10
	OASDI.....	127	0	57

¹ Lump-sum refund of employee's CSR contributions, without interest.

² Reduced lump-sum refund (employee's CSR contributions, without interest, reduced for employee-OASDI taxes).

³ Worker's basic benefit amount of \$71 actuarially reduced because of retirement at age 62.

NOTE.—70 percent of female workers with 10 to 19 years of Federal service unbroken by any refund of CSR contributions who separate between the ages of 30 to 39 claim a CSR refund within 6 months of separation.

Source: Social Security Administration Analytical Note No. 6-61.

Case F

Mr. F works 2 years under OASDI. He then works 10 years under CSR, separates from his Government job, and takes a refund. He then works 1 year under OASDI, when it is assumed that he (1) becomes disabled, or (2) dies.

	System paying benefits	Monthly disability benefits		Monthly survivor benefits, widow and 1 child
		Worker alone	Worker, wife and 1 child	
Present law	CSR	1 0	1 0	1 0
	OASDI ²	0	0	0
Transfer-of-credit plan	CSR	3 0	3 0	3 0
	OASDI	\$127	\$254	\$191

¹ Lump-sum refund of employee's CSR contributions, without interest.

² Under OASDI, worker is not insured for disability because he does not meet the requirement of 20 quarters' coverage during the 40 quarters preceding quarter of disability. He is not insured for survivor benefits because he is not fully insured (needs 13 quarters of coverage; has 12), and is not currently insured (6 quarters of last 13 before quarter of disability or death).

³ Reduced lump-sum refund (employee's CSR contributions, without interest, reduced for employee OASDI taxes).

NOTE.—80 percent of male workers with 10 to 19 years of Federal service unbroken by any refund of CSR contributions who separate between the ages of 30 to 39 years claim a CSR refund within 6 months of separation.

Source: Social Security Administration Analytical Note No. 6-61.

Case G

Mr. G works 2 years under OASDI. He then works 10 years under CSR, separates from his Government job, and does not take a refund. He then works 1 year under OASDI, when it is assumed that he (1) becomes disabled, or (2) dies. (Identical to case F except no refund.)

	System paying benefits	Monthly disability benefits		Monthly survivor benefits, widow and 1 child
		Worker alone	Worker, wife and 1 child	
Present law	CSR	1 0	1 0	2 0
	OASDI	0	0	0
Transfer-of-credit plan	CSR	3 0	3 0	4 0
	OASDI	0	0	\$191

¹ If no refund is elected before age 62, worker is entitled to monthly benefit of \$65 if he attains that age.

² Survivor receives lump-sum refund of employee's CSR contributions, without interest.

³ Same benefit as in footnote 1, but if, before age 62, a reduced lump-sum refund is elected (forfeiting CSR benefit at age 62), OASDI benefit becomes \$127 (worker alone) or \$254 (worker and family).

⁴ Survivor receives reduced lump-sum refund (employee's CSR contributions, without interest, reduced for employee OASDI taxes).

Case H

Mr. H works 24 years under CSR. He then separates from his Government job, taking a refund, and works 12 years under OASDI, when it is assumed that he (1) becomes disabled, or (2) dies.

	System paying benefits	Monthly disability benefits		Monthly survivor benefits, widow and 1 child
		Worker alone	Worker, wife and 1 child	
Present Law	CSR	1 0	1 0	1 0
	OASDI	\$74	\$124	\$111
Transfer-of-credit plan	CSR	2 0	2 0	2 0
	OASDI	127	254	191

¹ Lump-sum refund of employee's CSR contributions, without interest.

² Reduced lump-sum refund (employee's CSR contributions, without interest, reduced for employee OASDI taxes).

NOTE.—55 percent of male workers with 20 to 29 years of Federal service unbroken by any refund of CSR contributions who separate between the ages of 40 and 49 claim a CSR refund within 6 months of separation.

Source: Social Security Administration Analytical Note No. 6-61.

Case I

Mr. I works 24 years under CSR. He then separates from his Government job, not taking a refund, and works 12 years under OASDI, when it is assumed that he (1) becomes disabled, or (2) dies. (Identical to case H except no refund.)

	System paying benefits	Monthly disability benefits		Monthly survivor benefits, widow and 1 child
		Worker alone	Worker, wife, and 1 child	
Present law	CSR	10	10	20
	OASDI	\$74	\$124	\$111
Transfer-of-credit plan	CSR	30	30	40
	OASDI	74	124	191

¹ If no refund is elected before age 62, worker is entitled to monthly benefit of \$177 if he attains that age.

² Survivor receives lump-sum refund of employee's CSR contributions, without interest.

³ Same benefit as in footnote 1, but if, before age 62, a reduced lump-sum refund is elected (forfeiting CSR benefit at age 62), OASDI benefit becomes \$127 (worker alone) or \$254 (worker and family).

⁴ Survivor receives reduced lump-sum benefit (employee's CSR contributions, without interest, reduced for employee OASDI taxes).

Case J

Mrs. J starts working at age 18 and works 4 years under CSR. She then separates from her Government job. After 6 years at home, she works 2 years under OASDI, when it is assumed that she (1) becomes disabled, or (2) dies.

	System paying benefits	Monthly disability benefits		Monthly survivor benefits, 2 children ¹
		Worker alone	Worker, and 2 children	
Present law	CSR	20	20	20
	OASDI ³	0	0	\$147
Transfer-of-credit plan	CSR	40	0	0
	OASDI	\$127	\$254	191

¹ Worker's husband not dependent on her.

² No annuity benefit. Lump-sum refund of employee's CSR contributions plus interest.

³ Worker not entitled to social security disability benefits, but is currently insured so as to entitle children to survivors benefits.

⁴ No annuity benefit. Reduced lump-sum refund (employee's CSR contributions plus interest, reduced for employee OASDI taxes).

Case K

Mr. K works 16 years under CSR. He then separates from his Government job, taking a refund, and works for 4 years for a municipality in a position not covered under OASDI, after which he works under OASDI until he attains age 60 (18 years). He applies for retirement benefits under OASDI at age 62.

	System paying benefits	Monthly retirement benefits	
		Worker alone	Worker and wife at age 62
Present law	CSR	10	10
	OASDI ²	\$47	\$66
Transfer-of-credit plan	CSR	30	30
	OASDI ²	94	139

¹ Lump-sum refund of employee's CSR contributions, without interest.

² Benefit amounts have been actuarially reduced because of retirement at age 62 instead of age 65. The worker's unreduced benefit amount at age 65 under present law would be \$59, and under a transfer-of-credit plan \$118.

³ Reduced lump-sum refund (employee's CSR contributions, without interest, reduced for employee OASDI taxes).

NOTE.—80 percent of male workers with 10 to 19 years of Federal service unbroken by any refund of CSR contributions who separate between the ages of 30 and 39 years claim refund within 6 months of separation.

Source: Social Security Administration Analytical Note No. 6-61.

APPENDIX G

RECOMMENDATION REGARDING FEDERAL EMPLOYMENT IN REPORT OF
THE ADVISORY COUNCIL ON SOCIAL SECURITY ¹¹

Social security credit should be provided for the Federal employment of workers whose Federal service was covered under the civil service retirement system but who are not protected under that system at the time they retire, become disabled, or die.

Unlike almost all private pension plans and a high proportion of State and local retirement systems, the Federal civil service retirement system is not supplementary to the social security program. Thus when a person leaves Federal employment, his years of previous Federal service do not count toward social security benefits. Moreover, protection under the civil service retirement system does not start until after 5 years of Federal employment. As a result, although the civil service retirement system provides good protection for people who stay in Federal employment, Federal workers who leave, or those who die or become disabled before having worked for the Government for 5 years, may have inadequate protection or none at all under either civil service retirement or social security.

A practicable and relatively inexpensive way of filling the most serious gaps that result from this situation is to provide for social security credit for the Federal employment of those workers who are not protected under the civil service system at the time they retire, become disabled, or die. As part of the financing arrangement, the civil service retirement system would withhold, from the returns of contributions that are made from the civil service retirement system to separating employees, amounts equal to the social security employee contributions which would have been payable if their Federal work had been covered under social security. These withholdings would be transferred to the social security fund and additional financial adjustments made between the two systems to take account of the transfers of credit.

The plan includes the following principal elements, all of which the Council considers essential to its effective operation:

(1) Credit would be transferred to social security for the Federal service of individuals who die, become disabled, or separate from work covered under the civil service retirement system after less than 5 years of Federal service. (At present, the only provision made where a person with less than 5 years of service dies or terminates his employment is for a refund of employee contributions.)

(2) Credit would be transferred to social security for the Federal service of people who separate after 5 or more years of Federal work and obtain refunds of their contributions to the civil service retirement system. (The civil service retirement system does not provide any protection for people who separate from the civil service and take refunds.)

(3) Former civil service employees who have not taken refunds of their civil service contributions and who die or who become disabled before age 62 could have credit for their Federal service transferred to social security. (Former employees do not have disability or survivorship protection under the civil service retirement system after separation.)

This transfer-of-credit approach would forgo certain advantages which would be achieved by a straight extension of social security coverage. For example, an extension of social security coverage would provide superior protection for workers who become disabled or die relatively early in their careers. However, the transfer-of-credit approach the Council is suggesting would be considerably less costly for the Federal Government than a straight extension of social security coverage. Equally important, whereas an extension of social security coverage would require substantial modification of the civil service retirement system to take account of social security benefits and contributions, no modifications would be required to carry out the Council's recommendation except for the financing of the transfer of credits.

¹¹ "The Status of the Social Security Program and Recommendations for Its Improvement," report of the Advisory Council on Social Security, Washington, D.C., 1965 (pp. 79-81).

APPENDIX H

OPERATION OF THE RAILROAD RETIREMENT-SOCIAL SECURITY MINIMUM PROVISION IF APPLIED TO THE CIVIL SERVICE RETIREMENT SYSTEM ¹²

As part of the social security-railroad coordination a railroad worker is assured, under a minimum guarantee provision, that the total amount of the annuities paid to him and his family will not be less in any month than 110 percent of the amount they would have received if the employee's railroad service after 1936 had been covered under social security. The following discussion indicates the effects of applying this kind of guarantee to the civil service retirement system (modified as indicated in ¹²) as an addition to provisions of approach No. 5.

DEATH OR DISABILITY IN SERVICE

As the attached tables show, the social security minimum provision would have a great effect upon these types of civil service annuities in many cases. The guarantee would be particularly helpful in cases where the death or disability occurs before the worker nears retirement age, and where he leaves a widow who has children under age 18. Where the worker dies in service leaving a widow but no children, the guarantee could have no effect until the widow reaches age 62, as social security does not provide benefits for widows without children before that age. Where a worker becomes disabled and has a wife but no children the guarantee could have some immediate effect as social security pays disability benefits to workers in such situations; however, the guarantee would have much less effect than when the disabled worker had a wife and young children, as social security would also pay dependents benefits in such cases.

The cases all assume continuous Federal work since age 22. This was done in the interest of simplicity, and also because such cases are the most representative. However, if the worker qualified for an OASDI benefit on the basis of non-Federal work the social security minimum provision would have much less effect, or no effect, on the civil service retirement system annuity amounts. The worker could of course qualify for OASDI benefits through non-Federal work done before his Federal service, during breaks in his Federal service, or by part-time jobs while in Federal service.

RETIREMENT, AND DEATH AFTER RETIREMENT

Over the long-run (i.e., after the effect of the 1950 new start wears off) the social security minimum provision would have very little effect in these types of cases, and consequently no benefit tables are presented. Civil service benefits for career civil service workers, and for their widows in cases of death after retirement, would almost always be higher than the amount of the social security minimum. Short-term civil service workers would ordinarily qualify for OASDI benefits based on non-Federal work, and so the social security minimum would not increase the civil service annuity. (Almost all married civil service annuitants provide at least \$3,600 of their civil service retirement annuity—or all of it if it is lower—as the base for widow's benefits, and the above is based on the assumption this practice would continue. Some provision might be needed to prevent the protection provided under the social security minimum from leading retirees to decide not to choose to come under the present civil service retirement provisions for providing widow's annuities.)

RELATIONSHIP TO THE SOCIAL SECURITY MINIMUM PROVISIONS OF THE RAILROAD RETIREMENT ACT

It would seem necessary to have provisions in both the Railroad Retirement and Civil Service Acts to coordinate the operation of the two minimum provisions in the case of persons with both railroad and civil service work. Otherwise, the widow and children of an individual, for example, who worked 10 years under the Railroad Retirement Act and 5 years under civil service could receive an annuity under the Railroad Retirement Act equal to the maximum benefit payable under the Social Security Act, and a very substantial annuity under the civil service system based on the social security minimum. If the worker had several children, the survivors could, in the absence of coordinating provisions, receive the Social Security Act maximum under both programs.

¹² It is assumed, in both the discussion and examples, that the social security minimum provision, if applied to the civil service retirement system, would be applied as 100 percent (rather than 110 percent, as under the railroad program) of the benefits as computed under the social security benefit formulas.

ADMINISTRATION

The administration of the social security minimum provision is relatively difficult, and involves much exchange of information between the railroad retirement and social security programs. The railroad retirement staff of course must make continuing computations and recomputations under the social security benefit provisions, and must take account of the operation of the social security retirement test, and other social security provisions affecting social security benefit amounts. The railroad retirement system must know not only about OASDI benefits actually payable, but also about OASDI benefits which a railroad retirement annuitant is eligible for but has not filed for, as the social security minimum provision takes account of OASDI benefits payable, whether or not the individual has claimed them.

CIVIL SERVICE SURVIVORS BENEFITS—SOCIAL SECURITY MINIMUM PROVISIONS

TABLE 1.—*Illustrative monthly benefits payable to a widow with 1 minor child where the worker dies while in Federal employment*¹

CSR average pay ²	Years of Federal service					
	5	10	15	20	25	30
\$4,000:						
Present law.....	\$65	\$81	\$99	\$118	\$136	\$154
Social security minimum.....	168	168	168	168	168	168
\$6,000:						
Present law.....	71	95	122	150	177	205
Social security minimum.....	191	191	191	191	191	(³)
\$10,000:						
Present law.....	85	124	170	216	262	308
Social security minimum.....	191	191	191	(³)	(³)	(³)

¹ It is assumed the worker enters Federal service at age 22 and works continuously in Federal service until his death.

² Average pay during 5 highest earnings years in Federal service. Average earnings under OASDI are assumed to be this amount or \$4,800, whichever is less.

³ Not effective.

NOTE.—CSR benefits are payable to a widow regardless of her age. Social security benefits are payable to a widow under age 62 only if she has in her care a child of the worker who is entitled to social security benefits, so the social security minimum would not operate where the widow is under age 62 and has no children under age 18.

TABLE 2.—*Illustrative monthly benefits payable to a widow with 2 minor children where the worker dies while in Federal employment*¹

CSR average pay ²	Years of Federal service					
	5	10	15	20	25	30
\$4,000:						
Present law.....	\$115	\$131	\$149	\$168	\$186	\$204
Social security minimum.....	252	252	252	252	252	252
\$6,000:						
Present law.....	121	145	172	200	227	255
Social security minimum.....	254	254	254	254	254	(³)
\$10,000:						
Present law.....	135	174	220	266	312	358
Social security minimum.....	254	254	254	(³)	(³)	(³)

¹ It is assumed the worker enters Federal service at age 22 and works continuously in Federal service until his death.

² Average pay during 5 highest earnings years in Federal service. Average earnings under OASDI are assumed to be this amount or \$4,800, whichever is less.

³ Not effective.

See note, table 1.

CIVIL SERVICE DISABILITY BENEFITS—SOCIAL SECURITY MINIMUM PROVISIONS

TABLE 3.—*Illustrative monthly benefits payable to a disabled worker with wife and 1 child¹ where the worker becomes disabled while in Federal employment²*

CSR average pay ³	Years of Federal service					
	5	10	15	20	25	30
\$4,000:						
Present law.....	\$133	\$133	\$133	\$133	\$156	\$190
Social security minimum.....	224	224	224	224	224	224
\$6,000:						
Present law.....	200	200	200	200	231	281
Social security minimum.....	254	254	254	254	254	(⁴)
\$10,000:						
Present law.....	333	333	333	333	385	469
Social security minimum.....	(⁴)	(⁴)	(⁴)	(⁴)	(⁴)	(⁴)

¹ Where worker has no dependent child and his wife is below retirement age, the social security minimum would not produce a higher benefit.

² It is assumed that he enters Federal service at age 22 and works continuously in Federal service until disablement.

³ Average pay during 5 highest earnings years in Federal service. Average earnings under OASDI are assumed to be this amount or \$4,800, whichever is less.

⁴ Not effective.

NOTE.—There is no provision under CSR for the payment of benefits to dependents of a retired or disabled worker. Social security benefits are payable to the wife of a retired or disabled worker beginning at age 62, or under age 62 if she has in her care a child of the worker who is entitled to social security benefits. Social security benefits are payable to children under age 18 or over age 18 if disabled before that age. The social security minimum would have no effect where the worker has no dependent child and his wife is below retirement age because it would not produce benefits as high as those payable under the CSR benefit formula.

TABLE 4.—*Illustrative monthly benefits payable to a disabled worker with wife and 2 children¹ where the worker becomes disabled while in Federal employment²*

CSR average pay ³	Years of Federal service					
	5	10	15	20	25	30
\$4,000:						
Present law.....	\$133	\$133	\$133	\$133	\$156	\$190
Social security minimum.....	254	254	254	254	254	254
\$6,000:						
Present law.....	200	200	200	200	231	281
Social security minimum.....	254	254	254	254	254	(⁴)
\$10,000:						
Present law.....	333	333	333	333	385	469
Social security minimum.....	(⁴)	(⁴)	(⁴)	(⁴)	(⁴)	(⁴)

¹ Where worker has no dependent child and his wife is below retirement age, the social security minimum would not produce a higher benefit.

² It is assumed that he enters Federal service at age 22 and works continuously in Federal service until disablement.

³ Average pay during 5 highest earnings years in Federal service. Average earnings under OASDI are assumed to be this amount or \$4,800, whichever is less.

⁴ Not effective.

See note, table 3.





SOCIAL SECURITY AMENDMENTS OF 1965

Mr. MADDEN. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 322 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 322

Resolved, That upon the adoption of this resolution it shall be in order to move that the House resolve itself into the Committee of the Whole House on the State of the Union for the consideration of the bill (H.R. 6675) to provide a hospital insurance program for the aged under the Social Security Act with a supplementary health benefits program and an expanded program of medical assistance, to increase benefits under the old-age, survivors, and disability insurance system, to improve the Federal-State public assistance programs, and for other purposes, and all points of order against said bill are hereby waived. After general debate, which shall be confined to the bill and continue not to exceed ten hours, to be equally divided and controlled by the Chairman and the ranking minority member of the Committee on Ways and Means, the bill shall be considered as having been read for amendment. No amendment shall be in order to said bill except amendments offered by direction of the Committee on Ways and Means. Amendments offered by direction of the Committee on Ways and Means may be offered to the bill at the conclusion of the general debate, but said amendments shall not be subject to amendment. At the conclusion of the consideration of the bill for amendment, the Committee shall rise and report the bill to the House with such amendments as may have been adopted, and the previous question shall be considered as ordered on the bill and amendments thereto to final passage without intervening motion except one motion to recommit with or without instructions.

Mr. MADDEN. Mr. Speaker, I yield 30 minutes of my time to the gentleman from Ohio [Mr. Brown], and at this time yield myself such time as I may consume.

This rule makes in order H.R. 6675, a comprehensive bill dealing in detail with the manner in which to provide hospital insurance, health benefit, and medical assistance for the aged folks of our Nation.

This legislation has been on the agenda of Congress, in one form or another, for the last 20 years. The members of the Ways and Means Committee are deserving of the highest commendation for the outstanding work they have done over the years to enact a practical bill which will relieve the critical health problem of our older citizens.

Years ago, older folks who were destitute or with insufficient income, property, or means to provide for the health needs in their declining years, were committed to so-called poorhouses, county or city hospitals throughout the land. Over the years, millions of older citizens have spent their declining days in inadequate so-called poorhouses or county institutions in poverty and disgrace until the day that their lives ebbed away.

When I came to Congress 20 years ago, one of the burning issues in my district was the necessity for something to be done to expand hospital and medical care, not only for the older citizens but for many younger families who were unemployed and in need of hospital and medical care. In many areas throughout our Nation during the last 25 to 30 years communities were victims of a pitiful lack of hospital accommodations and, in a great many areas, a scarcity of doctors.

LACK OF MEDICAL SCHOOLS

I well remember after World War II when thousands of boys were returning to civilian life many of them whose education was temporarily interrupted by military service, wanted to enter medical schools throughout our Nation. We found that medical schools and colleges were scarce and also hospital facilities and doctors both in urban and rural areas. I received hundreds of letters from veterans whose applications to medical schools were rejected because of the lack of accommodations. In 1947, I asked one of the trustees of Indiana University why it was that so many boys who had applied from my area to this medical school were rejected and he stated that out of approximately 3,000 applications in 1946, the University's Medical School only had accommodations for 150.

I remember when, in the late 1940's, we had legislation on the floor of the House to appropriate money for hospital and medical school construction, we were always met with organized opposition by the American Medical Association who spent vast sums propagandizing against any aid from the Government to build hospitals, provide money to educate students for the medical profession, or to expand medical services to millions who were suffering by reason of inadequate facilities.

The bill we are considering today, if enacted into law, will be one of the great landmarks of progress taken by our Government in order to help carry out humanitarian considerations which it owes to millions of older folks throughout the land who have devoted their lives to making this Nation of ours the leader of the world.

FINANCES OF ELDERS

In the last 20 years, the number of older people in our Nation has almost tripled. Now, 1 American in every 10 is in the older group and this number is increasing every year. Medical and hospital care is a serious problem for many Americans of all ages but the older folks are more helpless and have more health afflictions. Of the 18 million people over 65, more than half have incomes of less than \$1,000 a year. The

average income for two-person families is around \$2,500 per year. Incomes like this will buy very little hospital or medical care. About 6 million Americans over 65 years of age have no assets at all. They are in abject poverty. When an aged husband or wife is hospitalized, the medical bills average around \$800 a year. People over 65 use three times as much hospital care as younger people. Their stay at the hospital is twice as long as the average younger person. Medical costs have increased 63 percent since 1950, and in the same period hospital rooms have gone up 154 percent. Few older folks have savings to meet these skyrocketing hospital and medical costs.

As one reviews the history of medicare legislation and the fact that after 20 years the Congress is about to assume its responsibility to correct one of the most flagrant inequities and humanitarian omissions in correcting an injustice to a large segment of our American citizens.

The recent edition of April 12 Newsweek magazine has an interesting article dealing with this problem. They state in this article that from the period of 1940 to 1960 that taxpaying citizens have increased from 35 to 72 million and the number of citizens over 65 in that 20-year period has increased from 600,000 in 1940 to 12 million in 1960. Our population is increasing annually and through modern scientific discoveries in medicine and surgery; our older folks are increasing in numbers far more rapidly than the similar increase of population of 25 years ago. The problem of medical and hospital care for our older citizens is far more critical than after World War II and will increase by alarming proportions every year unless legislation like we are considering today is enacted into law in an effort to solve this problem of hospital and medical care for the elderly.

MEDICARE BILL

The Rules Committee in reporting this bill out, has provided for 10 hours debate. H.R. 6675, very briefly, covers all persons over 65, with benefits commencing July 1, 1966, with one exception. Up to 60 days of full hospital care per illness, with patient paying only the first \$40. From 20 to 100 days of post-hospital care in an affiliated facility for each spell of illness—this coverage to begin January 1, 1967. Outpatient diagnostic services following payment of \$20 deductible. Posthospital home health services up to 100 visits per spell of illness. Payments made directly to hospitals, and so forth.

Voluntary supplementary plan: Coverage for all persons over 65 enrolling before March 30, 1966, or as they reach 65. In exchange for \$3 monthly premium—\$6 for a couple—enrollees will be covered for 80 percent of these additional services following payment of \$50 annual deductible: physicians' and surgical services, up to 60 days per illness in a mental hospital—180-day lifetime maximum—up to 100 visits per year for home health services without prior hospitalization, diagnostic tests, X-ray, radium and radioactive isotope therapy, ambulance services under limited con-

ditions, surgical dressings, rental of durable medical equipment, and so forth. Plan to be administered by private companies like Blue Cross. Benefits effective July 1, 1966.

Financing of the basic plan will be through an additional social security tax applying equally to employees, employers and self-employed persons.

AMERICAN MEDICAL ASSOCIATION ELDERCARE

During the 2 days hearing before the Rules Committee several alternative bills, amendments or changes were presented to the pending legislation. The principal substitute was a bill sponsored by the strategy board of the American Medical Association called eldercare. Under this proposal the AMA would let the individual States, who would accept a health program, pay half the costs and administer it themselves. Each State under this bill would decide whom to help, if any one and how much. This proposal is more or less an extension of the wholly inadequate Kerr-Mills legislation passed by the Congress several years ago which has proven a miserable failure as far as a solution to the Nation's health problem is concerned.

During this time nine States have absolutely refused to pass any legislation under the Kerr-Mills provisions. Out of the 41 States who have made any effort under the Kerr-Mills law, only 7 States have anything like adequate programs and in these seven States some have omitted essential factors of hospital care for the aged. These seven States have omitted to provide any uniform treatment of older people. During this debate you are going to hear a great deal about eldercare because the political department of AMA has carried on a multimillion-dollar campaign over the Nation through television, radio, mail and newspapers, misrepresenting the true facts about eldercare. In their propaganda they do not state that eldercare is merely Kerr-Mills all over again with a little window dressing to mislead the American people.

Taken on the basis of official Government reports on the operation of the Kerr-Mills program, if applied in all 50 States, it would enable a maximum of about 3 million elder folks to qualify for benefits. Around 16 million older folks would get nothing.

The highly financed political campaign of the AMA strategy board so exaggerated and misrepresented the facts about eldercare that the gentleman from Florida, Congressman HERLONG, one of the two cosponsors of the eldercare bill, publicly condemned the AMA committee for its overenthusiastic and misleading propaganda. To quote Congressman HERLONG, he stated:

For the AMA to give the impression it provides complete coverage is not so.

He also said:

It just makes it available for the States to provide if they want to.

I am not criticizing the thousands of physicians over the Nation who are not familiar with the true facts. Most of them are openly or privately supporting the medicare bill and opposing the AMA eldercare plan.

I do hope that the Members of the House remain on the floor and listen to the presentation of this legislation by the members of the Ways and Means Committee, which held hearings on medical legislation in every session of Congress for the last 15 or 20 years on medicare legislation.

Chairman MILLS and older members of the Ways and Means Committee have devoted many weeks and months to this problem and I do hope that every member will listen to Chairman MILLS when he opens this debate after the House goes into Committee of the Whole. Chairman MILLS testified before our committee that this legislation is 100 percent financially sound for the present economic conditions in the Nation and that provisions in future financing were considered and incorporated into this legislation which will protect our social security system indefinitely into the future. Several years ago there was a great deal of argument that the private insurance industry could take care of this need for our elder citizens. When those arguments were surveyed, upon investigation it was found that thousands of aged as policyholders presented their opposition because of so many unreliable insurance companies throughout the Nation cancelling insurance policies when extended illnesses occurred to the insured. Many private insurance companies at that time experimented with combining their resources in order to offer special plans to older citizens on account of the economic situation involved with so many older policyholders. This experiment was a failure.

The American people, during the last dozen years, have become educated and informed on the true facts regarding medicare legislation. A nationwide poll was taken by the Harris people recently on medicare legislation covering rank and file Americans and the return revealed that the American people are for adequate medicare legislation by a margin of 2 to 1.

A LOCAL TAX SAVING BILL

Another angle connected with this legislation which has not been discussed is that millions of younger folks are indirectly being benefited in that they can use their small income for educational purposes instead of leaving grade school or high school to work and provide hospitalization and medical care for their parents. These younger folks will be given an opportunity to meet the problems of this advanced scientific age and be producers and taxpayers instead of eventually becoming members of the unemployed and thus becoming a problem eventually for Government aid and assistance.

Another consideration that did not come out in the hearings has been the fact that the passage of this legislation will save multimillions of dollars to the American taxpayer in local areas where they are financing county and city hospitals, poor houses, welfare departments, and other local agencies caring for sick and dependent elder citizens. This morning I telephoned the public welfare department in my district, Lake County, Ind. They informed me that during the

first 3 months of 1965, \$290,000 was spent for hospital, medical, and nursing home care for the elder citizens of Lake County. Lake County taxpayers will be relieved eventually of about \$11 million in taxes annually when this legislation gets organized and in full operation.

In closing let me say that the greatest testimonial for this legislation, coupled with the educational legislation passed several weeks ago, was the returns of the recent election of November 5, 1965. By a majority of over 15 million, President Johnson and Vice President HUMPHREY won an unprecedented victory and the principal plank in their platform was education and medicare. Dozens of new Members—freshmen—are in Congress today, because the American people have finally become informed on these two great national issues—education of our youth and hospital and medicare for our elder citizens.

(Mr. MADDEN asked and was given permission to revise and extend his remarks.)

Mr. BROWN of Ohio. Mr. Speaker. I yield myself 10 minutes.

(Mr. BROWN of Ohio asked and was given permission to revise and extend his remarks.)

Mr. BROWN of Ohio. Mr. Speaker, my colleague on the Rules Committee, the gentleman from Indiana, devoted most of his time to a discussion of the bill, or what he understands may be the bill, and little time to explaining the rule.

The rule bringing this bill to the floor is a closed or a gag rule providing for 10 hours of general debate and permitting the offering of no amendments from the floor except those reported by the Ways and Means Committee itself. It provides for one motion to recommend, either with or without instructions.

I have stood in this well many times in the past in opposition to the voting of closed or gag rules. I have the very firm conviction and belief that within the House of Representatives we have sufficient judgment, wisdom, and ability to pass upon legislation, even in detail, at least as ably as the other legislative body across the Capitol, where there are no restrictions on the offering or consideration of amendments and no limit on the debate on such amendments or on the legislation itself.

I want the Record to be made very clear. In the Rules Committee when the question of a rule on this particular bill, H.R. 6675, came up, I moved a substitute for the motion of the gentleman from Indiana [Mr. MADDEN], who had moved that we report the bill under a closed or gag rule and 10 hours of debate. I moved that we report the bill under an open rule which would give every Member of the House an opportunity to offer any amendment, and a full opportunity for such amendments to be considered and debated on the floor of the House. That motion was voted down.

Then another motion was made as a substitute for the Madden motion, to provide that the so-called Herlong-Curtis bill should be considered in order as an amendment to the bill. That was voted down.

Then, finally, a motion was made to amend the motion of the gentleman from Indiana so that the closed or gag rule would provide for the offering and consideration of H.R. 7057, the so-called Byrnes bill, with which Members are all acquainted, on the floor of the House, so that it might be discussed and debated section by section. That was voted down by a fairly narrow margin.

We now have before us this rule, a closed, gag rule, which means that the House may not work its will and no Member may offer an amendment unless it has the sanction of the Committee on Ways and Means, except in the case of a motion to recommit, which is always reserved as a right to the minority.

Now, I do not know how much time my colleagues have devoted to studying this bill or how much attention has been given to it. I am sure my good friend, the gentleman from Indiana [Mr. MADDEN], has studied it very carefully, but frankly I do not know all that is in this bill and I cannot answer all the questions that might be asked about it. I am not sure there is anybody in the House who can answer all of the questions that might arise in connection with this legislation. There are 296 pages in this bill. The report alone contains 264 pages. I cannot help but wonder in my own mind as to why the great haste. We were asked to rush it through the Committee on Rules and it was rushed through the Committee on Rules with a day and a half of hearings. It was reported out of the Committee on Ways and Means as it is in its present form without hearings on many sections of the bill, some of them being the most important part of it. I cannot help but wonder why the haste. The insurance and medicare provisions of this bill will not become effective until a year from next July. The increased benefits to those now on the social security rolls will be retroactive to last January 1. That is helpful and can be handled very quickly and should have been handled last year. There is a great deal of mystery to me about this bill, and why it is before us in its present form. I still do not understand, and I have been in Congress for a long, long time all of these things that are going on. This is a great piece of machinery—this legislative machine here on Capitol Hill—and we have had this bill or a bill like it before the Committee on Ways and Means for a great many years.

In fact, this particular type of bill has been before the Committee on Ways and Means since 1955. Year after year and Congress after Congress, the Committee on Ways and Means, substantially constituted as it is now, has failed and refused to report a medicare bill or to endorse the philosophy and the program that is outlined in this measure. Then suddenly the Committee comes out with a bill that covers the waterfront. As somebody described it, it provides for every situation from the cradle to the grave.

As I understand it, there are three or perhaps four important divisions of this bill which we have to consider. Toward

one part of the bill there is no argument. That is the part which I think everyone favors. It is the part that gives an increase of 7 percent across the board, with a minimum of \$4 a month, as an increase in social security benefits to those now on the social security rolls. It would enlarge the coverage to give greater protection to widows and children and to certain disabled persons. That section of the bill has a unanimous report from the committee, I believe, and perhaps will in the House.

Another section of the bill applies to hospital and nursing home care. This will be furnished under social security and paid for by increased social security taxes.

Another section of the bill will establish for the first time a new system of voluntary medical insurance, by which individuals over 65, either by having \$3 a month deducted from social security benefits or by paying \$3 into a Federal fund, can be protected against certain medical or surgical expenses and other expenses not covered by the medical care section of the bill.

Finally there is another section of the bill which will not only increase social security taxes to a total of 11.2 percent, paid by the employer and employee equally, but additionally will increase the amount of income taxable for social security purposes first to \$5,600 and then to \$6,600 per year in order to help finance this program.

The total program, as I understood the testimony before the Committee on Rules, would carry an additional cost of \$6.2 or \$6.3 billion. No one is certain in his own mind what the cost will be, because it is now a matter of conjectures and estimates.

The real debate and discussion surrounding this bill in the Committee on Ways and Means and elsewhere is whether or not we should embark upon a new program of paying hospital and nursing home benefits through social security or whether it should be under some other, separate, system.

The gentleman from Wisconsin [Mr. BYRNES], the ranking member of the Committee on Ways and Means, has sponsored a bill, H.R. 7057, which provides for all hospitalization, nursing home care, or medical and surgical care to be financed through a voluntary system with a charge levied against the person receiving the benefit, and paid partially out of the Federal Treasury rather than from the payrolls of the employers of the Nation. The bill will be offered not as an amendment, because this rule will not permit the offering of any amendments, or debate except in a general way. It will be offered as a motion to recommit.

I suggest that careful attention be given to the bill itself, because it is a very involved piece of legislation. I also suggest close attention be directed to the motion to recommit.

Mr. Speaker, let me say just one other word in conclusion. Today about one-half of the case mail the average congressional office receives deals with social security cases. If this bill is passed

in its present form, because of its intricate and wide coverage, I predict here and now that we will need that fourth office building and additional staff just to answer the inquiries on social security matters. I can see ahead of us a great deal of inquiries from people who believe this legislation is going to give them benefits much greater than a careful study of the bill will convince you that it does give them. It does not give the people what they believe they are going to receive.

I want the Members to listen carefully to the debate concerning the cost to the individual recipient, as well as the cost to the taxpayers for the two programs.

Mr. GROSS. Mr. Speaker, will the gentleman yield?

Mr. BROWN of Ohio. I yield to the gentleman from Iowa.

Mr. GROSS. Is the reason for this gag rule the fear on the part of the majority of the Committee on Ways and Means and the majority of the Committee on Rules that the House would improve the bill, or is it notice to us that we are incompetent to deal with the bill?

Mr. BROWN of Ohio. Well, I am never sure why some people insist on having closed or gag rules. I have never believed in them, and I will permit the gentleman from Iowa to judge for himself the reason.

Mr. Speaker, I yield such time as he may consume to the gentleman from New York [Mr. FINO].

(Mr. FINO asked and was given permission to revise and extend his remarks.)

Mr. FINO. Mr. Speaker, over the past 12 years, on numerous occasions, I have spoken on the floor of this House to urge that we liberalize and humanize our social security system. I have introduced bills which would accomplish these results. While we have made progress in improving the system, I feel that we have not gone far enough in eliminating many unjust features still in the law.

Today, this bill—the Social Security Act of 1965—is more than a milestone—it is a landmark in the field of welfare and enlightened social security legislation. We all know that this bill is long overdue, especially the section which provides health insurance for the elderly. The legislative process is often long, and the wheels have turned slowly in this case, but as a result we can be sure that a good, carefully drawn bill has been produced. I will vote for it gladly with a relieved mind. I have been especially concerned about the problems of the elderly for many years. I know what a lengthy illness can do to precious, and essential savings. I know that too many of our elderly citizens fear the first signs of illness, because they are afraid they will not be able to pay the resulting bills, and will have to turn to some form of public assistance for relief. We owe the elderly more than this anxiety about their financial security, an anxiety which will increase as the cost of medical care rises. The Social Security Act of 1965 will give our citizens over 65 some meas-

ure of the economic security they deserve.

The bill establishes two coordinated health insurance programs for persons 65 or over. First, a basic plan, which will provide protection against the costs of inpatient hospital services, posthospital extended care, home health services, and outpatient diagnostic services. The bill provides for a deductible which the patient pays, and limits the days of illness which will be covered by the plan in any spell of illness.

This basic plan will be financed through a separate payroll tax and a separate Federal hospital insurance trust fund. Benefits for persons currently over 65 who are not insured under the social security or railroad retirement systems will be financed out of Federal general revenues.

The proposed Social Security Act also establishes a voluntary supplementary plan which would cover a substantial part of the cost of physicians' services and numerous other medical and health services. After an annual deductible of \$50 has been paid by the patient, the plan would cover 80 percent of the patient's bill. Individuals who enroll initially in the plan will pay premiums of \$3 a month, which will be deducted where possible from their social security benefits. The proposed 7 percent across-the-board increase in benefits which is also contained in the bill would more than cover the monthly premiums for this voluntary health insurance. The Government would match the premium with \$3 paid from general funds. To the greatest extent possible, the benefits will be provided through contracts with carriers who will administer the program. A State would be able to buy into the plan for its public assistance recipients who are receiving cash assistance. This, of course, would be an advantage both for the State and for the individuals concerned.

Now that we have the bill before us we can see that dire warnings about spiraling costs were unfounded. The wage base will be increased to \$5,600 a year beginning January 1, 1966, and to \$6,600 effective in 1971—a step many people have long advocated, and the increase in the payroll tax rate for both employer and employees will only be one-half of 1 percent until 1972, after that rising slowly until in 1987 the health insurance portion of the tax will be four-fifths of 1 percent. This is certainly a reasonable cost for the increased benefits all of us will enjoy.

We must pass this legislation without delay. Hearings have been held twice in the past few years, and certainly no bill has aroused so much support in the country as a whole. The aged are an increasing proportion of the population—their problems will be the problems of all of us, unless something is done to help them. This legislation moves many steps in the right direction.

However, I have been disappointed that the bill has not included a general reform of the social security system. Certainly I support the changes which have been made. But I would go a great deal farther along the path to an equitable,

logical system. The bill provides a 7-percent, across-the-board benefit increase, effective retroactively beginning with January 1965. Certainly this increase is long overdue—social security benefits have fallen far behind the rising cost of living, in spite of the urgings of those of us who are aware that the aged have not been allowed to share in our growing prosperity. My bill, H.R. 4774, provides for a 10-percent-across-the-board increase in benefits. I feel that this would supply a much more adequate amount for the millions of beneficiaries who are barely able to meet the price of necessities with their present benefits.

My bill H.R. 2606 would increase the minimum amount of monthly insurance benefit payments to \$50 whereas the present Social Security Amendments of 1965 would increase the minimum to only \$44. It is hard to believe that anyone could consider \$44 a month a decent income. Certainly my bill is considerably more realistic in providing a more reasonable sum for those who must try to live on their social security benefits.

The Social Security Act of 1965 also includes a provision to provide benefits, at an actuarially reduced level, to widows at age 60. The justification for this is obvious: widows, often left alone when they are older and unable to support themselves because of a lack of modern skills, need the income which social security benefits would give them. However, my bill, H.R. 4169, would provide that a widow under retirement age may continue to receive mother's insurance benefits at a reduced rate even though none of her children are under 18. This would especially benefit those widows in their late forties and fifties who have spent their time and energy raising a family, and then are suddenly left without any other income than their comparatively young children can provide. It seems only fair to provide these women with a measure of economic security.

I also suggest that it is time that the retirement age was lowered to keep up with the demands of our modern economy. The unemployment rate remains comparatively high, and many young men and women just out of school are unable to find jobs. Men and women over 50 sometimes need to retire: their health is not good, or they have other pressing reasons why their jobs have become too much for them. It is only logical to provide for these different needs. My bill, H.R. 1693, would give full benefits to men at age 60 and women at age 55.

At the very least, I feel that we should eliminate the penalty—the actuarially reduced benefit—which prevents many men and women who would be helped by relaxation of retirement from leaving their jobs at age 62. Just this small step, which would be relatively inexpensive, would have a beneficial effect on our entire economy.

The bill liberalizes the social security earned income limitations so that the uppermost limit of the band of \$1 reduction in benefits for \$2 in earnings is raised from \$1,700 to \$2,400. Although this is a change for the better, I have urged that the so-called retirement test

should be eliminated altogether. It prevents many well-qualified and eager men and women from holding any but the smallest kind of part-time job. Certainly it is wasteful to prevent such valuable human resources from working at what they are most suited for: retirement should be completely voluntary, and social security benefits, which have, after all, been earned, should not depend on an arbitrary earnings income maximum.

For the past 10 years I have introduced a bill which would extend coverage to dependent brothers and sisters of an individual who dies fully insured. At present, these people, who are unable to support themselves and may be considerably older than the working member of the family, have no way of obtaining benefits if their sole means of support dies. They must often have to turn to public assistance. It is unfortunate that an individual who supports his brother or sister has the added worry about what will happen to them if he dies.

A long-needed reform of the social security system has not been included in this bill. Federal employees should be allowed to join the social security program: at present, they are discriminated against for no logical reason.

Despite the above points, I am strongly in favor of the bill. It contains many provisions which I have suggested for many years. For 12 years I have introduced bills to provide for the payment of children's insurance benefits up to age 22 if they are attending school. At present, children's benefits are cut off when they reach the age of 18. This prevents many of them from attending college or vocational schools, or, in some instances when the mother is in financial need, even finishing high school. Children of deceased, retired, or disabled workers would be included as long as they are full-time students in school. By age 22 the great majority of these children will have finished their education and will be ready to support themselves. This change is certainly essential if we are to succeed in the American ideal that every child shall have the best education for which he is suited. It has been estimated that 295,000 children will benefit under this provision in 1965.

I am also pleased that cash tips have finally been included in the definition of wages. This reform is long overdue; for years service workers, who receive a third or more of their income in tips, have been entitled to only relatively small social security benefits. This change will insure them benefits more comparable to their actual earnings in the years in which they were employed. Employers, in determining wages, always take possible tips into account, and as a consequence the wage will be low.

Many other provisions are worth noting. The Federal share of payments under all State public assistance programs is increased a little more than an average of \$2.50 a month for the needy aged, blind, and disabled. The bill also removes the present restrictions on Federal matching in public assistance programs for needy individuals who are tubercular or psychotic and are in general

medical institutions. This should help both the individuals and the hospitals involved.

The Social Security Act of 1965 also improves and extends the Kerr-Mills program. The bill would establish a new title of the Social Security Act to extend the advantages of an expanded medical assistance program not only to the aged who are indigent but also to needy individuals or the dependent children, blind, permanently and totally disabled programs and to persons who would qualify under these programs if in sufficient financial need. Kerr-Mills has been found to be a useful way to provide for the basic medical needs of people who desperately need financial help. This section of the 1965 bill would make medical assistance available to more people who need it.

These social security amendments will indeed have far-reaching effects. They will improve the living conditions of 18 million beneficiaries; they will begin the vitally important task of providing health insurance for all aged Americans, whatever their financial conditions. With the passage of this bill we will be facing up to the economic realities of our time and adding a measure of security to our social security system which is in line with those realities. At the same time we will be helping to relieve the consequences of tragedy in millions of American homes. I am happy to support this bill.

Mr. BROWN of Ohio. Mr. Speaker, I yield 5 minutes to the gentleman from Missouri [Mr. HALL].

(Mr. HALL asked and was given permission to revise and extend his remarks.)

Mr. HALL. Mr. Speaker, I am appearing before this House as a physician in the Congress to avoid an act of omission, to point out that the rule, House Resolution 322 making in order H.R. 6675, as has been stated by the gentleman from Ohio [Mr. Brown], has no proved need, but at the same time realizing the facts of life and the weight of the Congress to object to no amendments and no points of order from the floor.

Furthermore, I urge support of the motion to recommit with instructions to strike all after the enacting clause and bring back forthwith as a substitute H.R. 7057.

Now, Mr. Speaker, the speculation of the gentleman from Indiana and his non-valid personal opinion concerning many matters other than the rule before us are old saws, worn red herrings being drawn across the trail, that hardly deserve the dignity of acknowledgment. But I submit that this is not the time when we should use the whipping boy of various organizations to bring the physiognomy and visage to a state of "color rubra" by our various expressions in an effort to kick or knock down legislation that will change the state of the Nation.

Mr. Speaker, the majority have the power in this Congress to do that which it wishes and there is no argument about that. So let us not batter again the old worn image of the physicians of America who simply want to take care of people in the best possible way for those people.

Mr. Speaker, it is an error to stand here and quote Whitaker and Baxter as the AMA consultant public relations specialists since, indeed, they have not worked for the AMA nor been retained by it in any manner or means since the Wagner-Murray-Dingell bill of 1947. We are this out of date in some of the statements and the acts of collusion about this organization which, indeed, has been refused television rights in its expression and its desire and its own way to get to the public the hoax of the political promise which, indeed, made the administration itself realize that it could not live with the promise of H.R. 1 made before election time.

This service was rendered, and properly so, by organized medicine. I will leave to the author of the Kerr-Mills Act the statement that only seven States have joined in putting that through their State assemblies. Surely that will be corrected to the figure of 44 States and Territories of our 54 of same, now participating in one degree or another in the existing law of the land, the Kerr-Mills Act. This has been done in spite of opposition from Federal agencies and with the support of medicine and insurers.

The bill now before this House is a bill that was produced in executive session. No public hearings were held in the 89th Congress, thus denying the public and Members of Congress the opportunity to become familiar with this multipaged bill and the report thereon. Even though the administration bill cannot be implemented without the co-operation of physicians, this bill was drafted with no regard for the opinions and comments of those who will be expected to furnish services.

The hospital, State, and Federal evaluation and control committees cannot work without the wholehearted and interested support of the organizations and persons most expert in patient-hospital turnover, and most shunned in developing this hodgepodge bill.

For the same reason—that is, closed hearings—I object to a closed rule. As bad as it may be to write legislation on the floor, it is better than by a small, weighted, and—yes, prejudiced—logic-tight group.

This House is considering a rule for 10 hours of debate. This is a serious matter, and change of the entire concept of medicine for our Nation is at hand.

Recent polls prove the people are unaware of the bill's content and at least these debates will be followed by the news media and the people as the House works its will.

I would have preferred, and did urge before the Committee on Rules, a rule for 20 to 30 hours of debate equally distributed, for full discussion and enlightenment here and across the Nation.

Mr. Speaker, the basis for quality medical care is the voluntary relationship between the doctor and patient. This would begin to disappear as the Government supplants the individual as the purchaser and provider of health services. For the first time this bill pro-

vides service benefits in lieu of cash benefits.

Are we to tell the people of America, the senior citizens, that they are not capable of determining this matter as against a ribbon clerk here in Washington? The result will inescapably be third-party intrusion in the practice of hospitalization and medicine. The physician's judgment would be open to question by others, not responsible for the patient's well-being. His diagnostic and therapeutic decisions would be subject to disapproval by those controlling the expenditure of tax money.

The abuse factor will fill hospital beds, and private patients will be denied or delayed in admission to the end that waiting lists will build up, and another costly crash program of hospital construction will ensue.

As physicians and health facilities become more and more subject to intervention in their work by Government employees, a decline of professionalism will be certain.

America today has the finest physicians in the world, a fact frequently demonstrated over the last decade when the Nobel Prizes have been handed out, by your life expectancy, by those seeking graduate training in this country, or the Anthony Edens, the Dukes of Windsor, the Grace Kelly Rainiers, and many others who come here for medical and surgical care.

This is not merely a controversy over whether Federal Government should tax one group of citizens to provide health care benefits indiscriminately, regardless of need, to another group. This is not merely a disagreement over the best means of providing health care for our older citizens. Rather, this conflict is testing whether art and science of medicine will be permitted to grow and flourish in freedom, and competitively, or whether progress in medicine will be stunted and shriveled by an excess of Government control. Its adoption would be another downward step toward loss of freedom of choice.

It is not the doctors who will suffer under this bill, insofar as their economic standing is concerned; physicians' income would probably be more assured, not less, if the administration's bill is enacted. It is principle, freedom, research, and private insurers who will suffer.

The substitute bill, H.R. 7057, is a voluntary approach to the problem, and it will insure the retention of the high quality of medical care for which America is better known than any other nation on earth.

Mr. Speaker, for the reasons and considerations stated I strongly believe the resolution should be voted down.

Mr. MADDEN. Mr. Speaker, I yield 5 minutes to the gentleman from New York [Mr. KEOGH].

(Mr. KEOGH asked and was given permission to revise and extend his remarks.)

Mr. KEOGH. Mr. Speaker, this is a day which many of us have long awaited. This date will take an historical place in the annals of constructive legislation enacted by the Congress in this century. Just as is true of all the great social

advances which have been accomplished, it has taken a number of years and much energy and effort to reach this point. It has, indeed, taken the sincere and persevering efforts of many outstanding men and women.

This momentous and historical legislation which we are about to consider is a monument to the brilliance, the wisdom, the leadership and, indeed, the outstanding statesmanship of the great and learned chairman of our Committee on Ways and Means, the gentleman from Arkansas. From its inception in 1789, the Committee on Ways and Means has been chaired by many truly able and dedicated men, but I can say with confidence and comfort that that great committee has never had a greater and more able or more dedicated chairman than the gentleman from Arkansas, WILBUR DAIGH MILLS.

I constantly marvel at his displays of truly brilliant qualities of statesmanship, and in this bill which will take its place alongside the original Social Security Act we have another example of what can be accomplished by such a dedicated and able legislator.

Those of us who have been privileged to sit by his side on the Committee on Ways and Means during the past months and years are deeply aware of those qualities which make him such a leader. It is only through this experience, perhaps, that one can really appreciate the many seemingly insurmountable problems through which he has guided the committee to acceptable and sound solutions. The legislation which we will consider is illustrative of this point. With such leadership the Nation is in sound hands.

Mr. Speaker, may I pay a highly deserved tribute to the ranking Democrat on the committee, the gentleman from California, our colleague [Mr. KNOX], who has been in the forefront of the fight for adequate medical care for our senior citizens for many years. In addition to earlier measures, he sponsored H.R. 4222 in the 87th Congress, H.R. 3920 in the 88th Congress, and H.R. 1 in this Congress, bill numbers which are familiar to all who have interested themselves in this subject. He deserves the highest commendation and gratitude of all of us. The bill which will undoubtedly pass tomorrow by an overwhelming majority will be a tribute to the deep and sincere compassion of the gentleman from California for the needs of our senior citizens.

Mr. Chairman, may I also observe that many members of the Committee on Ways and Means made meaningful contributions to the development of H.R. 6675. This bill is representative of the legislative process. Its many provisions bear the marks of those who have studied long and assiduously the many facets of the problems involved. To my colleagues on the committee I express my appreciation for the very fine contributions which they have all made to this legislation.

Finally, we would not be here mechanically or so well prepared, Mr. Speaker, were it not for the devoted dedication to duty of the chief counsel of the Commit-

tee on Ways and Means, Leo H. Irwin, the assistant chief counsel, John M. Martin, Jr., the minority counsel, William H. Quealy, and our special assistant with respect to this bill, from the Library of Congress, Fred Arner.

Mr. Speaker, much has been said of the time consumed in the hearings before the Ways and Means Committee. Let it be noted in the Record at this point that in this and the 4 preceding Congresses the Committee on Ways and Means has held public hearings comprising 46 days, at least 641 witnesses who appeared in person and were subjected to cross-examination and whose testimony has been reduced to 13 volumes, comprising some 7,607 pages. Many hundreds of additional statements were submitted for these printed records.

In addition thereto, the Committee on Ways and Means has consumed at least 77 days—both morning and afternoon—in executive session during this period on this subject.

I would point out in addition, Mr. Speaker, we have available on the committee table and in this Chamber 2 volumes of printed executive hearings conducted in this session comprising nearly 900 pages of the testimony of representatives of such groups as the American Hospital Association, American Medical Association, Blue Cross, Blue Shield, the insurance industry, and so forth.

So, Mr. Speaker, when the House adopts the pending resolution, which it most certainly will, the Committee of the Whole will, in my opinion, witness a debate in the finest traditions of the House, which debate will be dominated by the towering figure of the greatest legislative master of them all, the gentleman from Arkansas, and in which he will be joined by the seemingly confident, obviously conscientious, but fortunately outnumbered minority led by the talented gentleman from Wisconsin.

Mr. Speaker, on the morrow, too, when the evening shadows lengthen, as life has for so many millions of our elder citizens, this bill will pass, and to and of your House, Mr. Speaker, those millions of grateful Americans will say, "Well done; well done."

Mr. MADDEN. Mr. Speaker, I yield 10 minutes to the gentleman from Florida [Mr. PEPPER].

Mr. BOGGS. Mr. Speaker, will the gentleman yield?

Mr. PEPPER. I yield to the gentleman.

Mr. BOGGS. Mr. Speaker, before the distinguished gentleman from Florida begins his statement, I would like to say that the gentleman from New York [Mr. KEOGH] made a very fine statement and he passed out some well-deserved credit to this magnificent piece of legislation. He, of course, was modest and not able to tell of the very, very significant role he has played over the years in bringing this legislation about. I know of no man who has worked harder or diligently or more effectively and more ably on this legislation than the gentleman from New York [Mr. KEOGH].

Mr. PEPPER. Mr. Speaker, the poet Browning said:

Grow old along with me!
The best is yet to be,
The last of life, for which the first was made.

Mr. Speaker, what this House I believe will do within the next 2 days will contribute much to the realization of that poetic dream.

Within the last 2 weeks, Mr. Speaker, this House shall have made history in the passage of a bill opening doors of educational opportunity far exceeding anything ever known in this blessed land; and I hope by the end of tomorrow, we will have enacted this legislation which will remove the specter of fear of illness from the 19 million citizens of our country 65 years of age and over and remove the concern from the hearts of their children that a 60-day hospitalization would—if it did not jeopardize their very homes—probably exhaust their savings and impose upon them indebtedness burdensome for years ahead.

We all know, Mr. Speaker, that the income of the senior citizens of this country is much below the income of younger people, active in their occupations and earnings. For example, only about 20 percent of the aged have sufficient incomes to pay income tax. Of the aged who are on social security, all but about one-fifth rely on social security benefits as their major source of continuing retirement income.

In respect to assets, the picture is no more favorable. The average financial assets such as bank accounts, securities and the like, liquid assets, are of no significant value as far as the senior citizens are concerned.

In 1962, half of the aged couples of America had financial assets of less than \$1,350 and half of the nonmarried aged had less than \$400 of financial assets.

Now, Mr. Speaker, if one of these senior citizens with that inadequate income and with that kind of financial assets had to go to a hospital for 60 days—who would pay the bill? They do not have the money. It is not currently available from any other public source except the charity of the cities and counties and private institutions and private individuals and relatives of these senior citizens.

In my own district, the story was told me a little while ago of a son going into the home of his aged mother. When he approached the front door he could hear her gasping for breath. He rushed in. It was the aftermath of a recurrent heart attack and he said, "Mother, I must rush you to the hospital."

In her faltering way she said, "I do not have the money to go to a hospital." He said, "Mother, they will take you at Jackson Memorial Hospital and in the hospital you will be provided for." She said, "I do not want to be a charity patient in Jackson Memorial Hospital." And that faithful son said, "All right, Mother, my wife and I will mortgage our home to keep you out of a charity ward and to give you the hospital care which you require."

Imagine how light will be the hearts of the senior citizens of America, as a result of having the assurance that without burdening their children, without being charity patients in local hos-

pitals, without having to rely upon the bounty of their children or their friends, they can go to a hospital for 60 days for one spell of illness, under this bill, and get the care that they require.

We have not only provided that assurance of hospital care for 60 days for each spell of illness, which may be repeated, upon the certificate of a physician, after a lapse of another period when they have been out of the hospital, another 60 days, and so on, as long as their health needs require. But this bill goes further and for the first time provides medical services also for those over 65 who are ill.

How will that medical service be paid for, primarily? Those who are retired, drawing social security benefits, will get a minimum of \$4 per month under this bill, under the 7 percent across the board increase in their social security benefits; so they will get more than \$3. If they will voluntarily enroll for medical care under this bill, the Government will withhold \$3 it otherwise would give the individual, match that with another \$3, and buy a \$6 a month medical insurance policy to cover the individual, giving surgical services, medical services, diagnostic and therapeutic services, home-care treatment and attention and other benefits.

What a wonderful package it is, therefore, that we will make available to the senior citizens of this land.

There will be an attack, as there have been attacks in the past, upon the payment of these social security taxes by the younger workers. But the figures show that out of every senior couple in this country, at least one of the couples has to go to a hospital for at least once in the remaining days between retirement and death, and the average hospital cost is \$600 to such an individual. This is more than the average any worker will ever pay.

So the children of the senior citizens, the mothers and fathers of America, will have assurance that the burden of that 60-day illness of their parents, or whatever it may be, will not be upon them and that they will have their principal hospital and medical expenses provided for when they reach age 65.

Mr. Speaker, there are things which remain to be done. We do not provide in this bill for the aged chronically ill, as the committee well recognizes. I hope that will be one of the challenges of the future, and that we may find a way for those who have to stay in a hospital or a nursing home for a longer time than allowed by this bill will be succored while in that period of illness and confinement.

Mr. Speaker, in this legislation we deal with nothing less precious than the lives and the health, not to speak of the happiness, of the mothers and fathers of our land. One of the commandments says "Honor thy Father and thy Mother" I know of no way we can better honor the fathers and the mothers of America those who have borne the burdens of a generation, faced or been willing to face the enemy in war, borne the problems of a nation in peace, and developed a mighty land than to provide a program so that they will not feel, when they come to the end or almost the end of the day of life,

that they are either neglected or forgotten. I feel that this bill does honor and does justice to the mothers and fathers of America.

The rule is fair. I hope it will be adopted and that by the end of tomorrow this monumental legislation will become another of the glorious acts of this great House.

Mr. MADDEN. Mr. Speaker, I move the previous question.

The previous question was ordered.

The SPEAKER. The question is on the resolution.

The question was taken and the Speaker announced that the ayes appeared to have it.

Mr. HALL. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER. The Chair will count. [After counting.] Two hundred and eighteen Members are present, a quorum.

Mr. HALL. Mr. Speaker having exercised due process, I wish to do the same, and I now demand the yeas and nays.

The yeas and nays were refused.

The SPEAKER. The question is on the resolution.

The resolution was agreed to.

Mr. MILLS. Mr. Speaker, I move that the House resolve itself into the Committee of the Whole House on the State of the Union for the consideration of the bill (H.R. 6675) to provide a hospital insurance program for the aged under the Social Security Act with a supplementary health benefits program and an expanded program of medical assistance, to increase benefits under the old-age, survivors, and disability insurance system, to improve the Federal-State public assistance programs, and for other purposes.

The motion was agreed to.

IN THE COMMITTEE OF THE WHOLE

Accordingly, the House resolved itself into the Committee of the Whole House on the State of the Union for the consideration of the bill H.R. 6675, with Mr. DINGELL in the chair.

The Clerk read the title of the bill.

By unanimous consent, the first reading of the bill was dispensed with.

Mr. MILLS. Mr. Chairman, I yield myself 15 minutes.

Mr. Chairman, we are beginning the consideration, in Committee of the Whole, of H.R. 6675, a bill reported by the Committee on Ways and Means after consideration this year of many, many days in executive session involving a subject matter that has been before the committee for a number of years, a subject matter on which the Committee on Ways and Means has conducted over the course of that time more days of public hearings than on any other matter within the jurisdiction of the Committee on Ways and Means in the same period of time. This was pointed out by the gentleman from New York [Mr. KEOGH], during the debate on the rule a few minutes ago.

Mr. Chairman, the bill, H.R. 6675, involves some matters that have not been in bills submitted in prior years to the Committee on Ways and Means as a

single package or previously reported by the Committee on Ways and Means.

It is significant, however, Mr. Chairman, that the bill, H.R. 6675, contains all except one of the provisions that were in the bill last year that was reported from the committee providing for social security amendments and which the House passed by an overwhelming vote, as I recall, with only eight Members voting against that bill. At that time the committee thought it advisable to include a provision to permit firemen and policemen under existing State and local government pension plans so they could elect among themselves to come under social security. That provision was stricken by Senate action in the Finance Committee as it considered the bill last year and is not in this year's bill.

Mr. Chairman, after we met with the other body in conference, we felt it was advisable for us not to include the provision this year on the basis of the feeling that prevailed within the conference on that matter. But with that sole exception everything that you Members who were here last year and who returned to this Congress voted for in the social security amendments of last year is contained in this bill.

Mr. Chairman, I say there is material in it that was not in that bill. There is material in it this time that apparently is more controversial in nature than the material that prompted all Members of the House last year, save eight, to vote for the bill.

I believe with respect to that material which is in the bill, however, there seems to be more misunderstanding and more general statements of disapproval without foundation and fact than we want to permit to continue after we discuss the bill through these 10 hours of general debate.

Let me point out, Mr. Chairman, very briefly what some of the provisions are within the bill, most of which do not involve any controversy whatsoever, for most of these provisions are in a bill that the distinguished gentleman from Wisconsin [Mr. BYRNES] introduced last week in his name that were not controversial in the Ways and Means Committee itself to any great extent.

In bringing to you the contents of this bill permit me to divide the bill into four parts, for each of these four parts constitutes a separate subject matter for a monumental bill within itself.

These four parts are, first, the part dealing with the medical care of our elderly citizens; second, the part dealing with maternal and child health, crippled children, and mentally retarded programs; third, the part revising and improving the benefit and coverage provisions of the old-age, survivors, and disability insurance program and, fourth, the part improving and expanding the public assistance programs themselves.

Now, let us return to the first of these. What, in a brief way, is the committee bill proposing to do with respect to health insurance and medical care of those over 65? The bill divides in that respect into three parts. There is within the bill what we have called a basic plan providing protection against the

cost of hospital and nursing home care, financed through a separate payroll tax and using a separate trust fund.

The proposed basic hospital insurance would be provided—on the basis of a new section in title II of the act—for people aged 65 and over who are entitled to monthly social security benefits or to annuities under the Railroad Retirement Act. In addition, people who are now aged 65 or will reach age 65 within the next few years and who are not insured under the social security or railroad programs would nevertheless be covered under the basic plan. In July 1966, when the program would become effective, about 17 million people aged 65 and over who are eligible for social security or railroad retirement benefits, and about 2 million aged who would be covered under a special transitional provision, would have the proposed basic hospital insurance.

Included under the special provision would be all uninsured people who have reached 65 before 1968. As to persons reaching 65 after 1967, they would have to have the quarters of coverage that are indicated in the following table:

Quarters of coverage required for OASI cash benefits as compared to hospital insurance

Year attains age 65	Men		Women	
	OASI	Hospital insurance	OASI	Hospital insurance
1967 or before	6-16	0	6-13	0
1968	17	6	14	6
1969	18	9	15	9
1970	19	12	16	12
1971	20	15	17	15
1972	21	18	18	(1)
1973	22	21		
1974	23	(1)		

¹ Same as OASI.

As indicated in the table, by 1974 the quarter coverage required for cash benefits and hospitalization insurance benefits will be the same and the transitional provision will phase out.

Together, these two groups comprise virtually the entire aged population. The persons not protected would be Federal employees who retired after July 1, 1960, and have had the opportunity to come under the liberal provisions of the Federal Employees Health Benefits Act of 1959. Others excluded would be aliens who have not been residents of the United States for 10 years and certain subversives.

Currently, 93 percent of the people reaching age 65 are eligible for benefits under social security or railroad retirement and this percentage will rise to close to 100 percent as the program matures. Thus, over the long run virtually all older people will earn entitlement for the proposed hospital insurance.

Persons entitled to benefits under the hospital insurance plan would be eligible to have payments made for inpatient hospital care and for important additional benefits covering posthospital extended care, posthospital home health services, and certain outpatient hospital diagnostic studies.

Benefits would be payable for covered hospital and related health services furnished beginning July 1, 1966. Posthospital extended care benefits would be effective January 1, 1967.

The second part of the medical package provides for a voluntary supplementary program providing and making available money for the payment of physicians' fees and other medical and health services, which would be financed through a small monthly premium paid by the individual, equally matched by an amount from the general funds of the Treasury of the United States.

The voluntary supplementary plan would provide protection that builds upon the protection provided by the hospital insurance plan. It would cover physicians' services, additional home health visits, care in psychiatric hospitals and a variety of medical and other services not covered under the hospital insurance plan. The beneficiary would pay the first \$50 of expenses he incurs each year for services of the type covered under the plan. Above this deductible amount, the plan would pay 80 percent of the reasonable costs in the case of services provided by an institution or home health agency and 80 percent of reasonable charges for other covered services, with 20 percent being paid by the beneficiary.

Benefits under the supplementary plan would be provided for:

First. Physicians' services, including surgery, consultation, and home, office, and institutional calls.

Second. Medical and other health services. These would include:

(a) Diagnostic X-ray and laboratory tests and other diagnostic tests;

(b) X-ray, radium, and radioactive isotope therapy;

(c) Surgical dressings, splints, casts, and other devices for reduction of fractures and dislocations;

(d) Rental of durable medical equipment, such as iron lungs, oxygen tents, hospital beds, and wheelchairs;

(e) Prosthetic devices (other than dental) which replace all or part of an internal body organ;

(f) Ambulance services with limitations;

(g) Braces and artificial legs, arms, and eyes.

Third. Inpatient psychiatric hospital services for up to 60 days during a spell of illness—subject to a lifetime maximum of 180 days.

Fourth. Home health services for up to 100 visits during a calendar year—without a requirement of prior hospitalization.

The \$50 deductible would be applied on a calendar year basis, except that expenses the individual incurred in the last 3 months of the preceding calendar year would be counted as satisfying the deductible if they had been counted toward the deductible in that year. This special carryover provision would avoid requiring persons with substantial costs at the end of 1 year to meet the deductible perhaps early in the next year as though they had had no prior bills.

The third part of this medical package results from the thinking in the Ways and Means Committee last year and largely consists of the tentative decisions that were taken at that time for drafting purposes within the committee.

That has to do with the expansions and improvement of the existing program of medical assistance for the aged. We have made very material improvements within that program, permitting the States to continue to provide better benefits to more needy people and permitting the Federal Government to assist the States with respect to the financing of these benefits.

We have made provision, Mr. Chairman, within the framework of that program, to assist the States not only with respect to the medical problems of those who are 65 and over, but we have made provision to help them with respect to the costs of the medical expenses for the blind, for the disabled, and for families with dependent children. These are now provided in some form or other, and under varying formulas in some five titles of the Social Security Act. We have grouped those into one program, and we place that in the new title of the Social Security Act, title XIX.

The provision of medical care for the needy has long been a responsibility of the State and local public welfare agencies. In recent years, the Federal Government has assisted the States and localities in carrying this responsibility by participating in the cost of the care provided. Under the original Social Security Act, it was possible for the States, with Federal help, to furnish money to the needy with which they could buy the medical care they needed. Since 1950, the Social Security Act has authorized participation in the cost of medical care provided in behalf of the needy aged, blind, disabled, and dependent children—the so-called vendor payments. This method of providing care has proved popular with the suppliers of medical care, the agencies administering the programs, and the recipients themselves.

Several times since 1950, the Congress has liberalized the provisions of law under which the States administer the State-Federal program of medical assistance for the needy. The most significant enactment was in 1960 when the Kerr-Mills medical assistance for the aged program was authorized. This legislation offers generous Federal matching to enable the States to provide medical care in behalf of aged persons who have enough income for their basic maintenance but not enough for medical care costs. This program has grown to the point where 40 States and 4 other jurisdictions have such a program and 227,000 aged were aided in December 1964. Furthermore, medical care as a part of the cash maintenance assistance programs has also grown through the years until, at this time, nearly all the States make vendor payments for some items of medical care for at least some of the needy.

H.R. 6675 is designed to liberalize the Federal law under which States operate

their medical assistance programs so as to make medical services for the needy more generally available. After an interim period ending June 30, 1967, all vendor payments for medical care, including medical assistance for the aged, would be administered under the provisions of the new title. Until June 30, 1967, States might continue operating under the vendor payment provisions of title I, old-age assistance and medical assistance for the aged; title IV, aid to families with dependent children; title X, aid to the blind; title XIV, aid to the permanently and totally disabled; and title XVI, the combined adult program, or if they wish, they might move as early as January 1, 1966, to the new title. Programs of vendor payments for medical care will continue, as now, to be optional with the States.

I will pass to the second part of the bill as we have divided it this morning for the purposes of discussion. That has to do with services for the mentally retarded, and for the maternal and child health and crippled children's programs. There we have added to the amount of money that we will provide the States from the Federal Treasury to assist with respect to these problems of our children.

The third part of the bill dealing with amendments and improvements of the Federal old-age, survivors, and disability insurance program again has to be broken down, for there are several very important amendments in this part of the bill. We are providing an across-the-board increase in the amount of benefits that we pay under social security by 7 percent, with a minimum, so that no retired worker or widow, age 65 or over would receive less than a \$4 increase in his social security check. We are making that provision retroactive to the 1st of January 1965, because that was the date for the commencement of increases in such benefits under the legislation that passed both branches of the Congress last year, but did not emerge from the conference.

Second, we are continuing benefits to children up to age 22, where now they discontinue at age 18, provided that the child is attending a school. We provide actuarially reduced benefits for widows at age 60. And we are liberalizing the definition of disability and providing for payment for the sixth month of the waiting period for disability insurance benefits. This to me is one of the more important elements within the amendments to the old-age, survivors, and disability insurance program.

We are for the first time providing to some 355,000 people 72 years of age and older what we call a transitional benefit for people who have had—or their husbands have had—some connection with the program but for some reason or other not sufficient connection with the work force to qualify under the present more stringent eligibility requirements. We are providing for them this transitional benefit. There are about 355,000 of those people still living who would benefit. We are increasing the amount an individual is permitted to earn and continue to draw some part of his social security benefit without losing all of that benefit.

There are many amendments in addition to those that I have discussed, including the coverage of self-employed physicians, including cash tips as wages for the purpose of social security, liberalizing the income treatment for self-employed farmers, improving certain State and local coverage provisions, exempting certain religious groups opposed to insurance, and revising the tax schedule and the earnings base so as to fully finance these changes we are making, and thus assuring that these programs are going to continue to be maintained on an actuarially sound basis.

The fourth point of the bill is equally important, equally important to those that are involved and affected by it, for under this part of the bill we are increasing the Federal matching share for the needy-aged, the blind, the disabled, and families with dependent children.

The bill provides for an increase in the payments to public assistance recipients, effective January 1, 1966. The formula determining the Federal share of assistance payments is liberalized by increasing the Federal proportion of the payments in the first step of the formula and by raising the ceiling on Federal sharing in the second step of the formula. For the adult categories—OAA, APTD, AB, and for the combined program for the aged, blind, and disabled—the formula is changed from twenty-nine thirty-fifths of the first \$35 of the average assistance payment to thirty-one thirty-sevenths of the first \$37 of the average assistance payment. The ceiling is raised on the average payments from \$70 a month to \$75 a month. The provisions in the formula under titles I and XVI adding \$15 to the ceiling for vendor medical care payments in which there can be Federal participation and otherwise recognizing medical payments are not affected by this formula change, except that the steps of the statutory formula are rearranged to improve their equitable application.

For the program of AFDC, the formula change made in the bill would be from fourteen-sevenths of the first \$17 of the average payment per recipient to five-sixths of the first \$18 of the average assistance payment. The ceiling is raised from \$30 a month to \$32 a month. Under the bill, there would be an increase in Federal payments averaging about \$2.50 a month for the needy recipients in the adult assistance categories and an increase of about \$1.25 a month for the needy children and the adults caring for them. The level of aid provided the needy justifies this modest increase.

We are eliminating limitations on Federal participation in public assistance to aged individuals in tuberculosis and mental disease hospitals under certain conditions. We are affording the States broader latitude in disregarding certain earnings in determining need for aged recipients of public assistance. And we are making other improvements in the public assistance titles of the Social Security Act.

Let me briefly refer to the magnitude of this bill by looking to the scope of it, seeing the numbers of people who are affected directly and immediately by this legislation.

Under the basic plan, that is under the hospital insurance program for persons aged 65 or over, it is estimated that some 17 million insured individuals and some 2 million individuals who are not insured under social security or railroad retirement would qualify on July 1, 1966, for protection against the cost of those hospital benefits that we make available under the basic plan.

Then under the voluntary supplementary plan, it is estimated that of the 19 million eligible aged today, maybe 80 to 95 percent will participate. This means approximately 15 to 18 million individuals would be benefited by that part of the medical program.

The CHAIRMAN. The time of the gentleman from Arkansas has expired.

Mr. MILLS. Mr. Chairman, I yield myself 10 additional minutes.

Under the medical assistance for the needy provision of the bill, we anticipate that some 8 million people under State programs with the Federal Government assisting will receive medical protection and be benefited thereby.

Then under the old-age, survivors, and disability insurance part, where we make amendments that I have referred to, there are 20 million people today who will receive increased benefits as a result of the 7-percent across-the-board increase in their cash benefit payments.

There are 295,000 children who will benefit under the provision allowing them to receive benefits when they continue in school up to age 22.

There are 185,000 widows who we anticipate will participate at age 60, with an actuarially reduced benefit.

There are some 355,000 of these people 72 years and older who will be eligible to receive the transitional social security benefit for the first time.

There are about 155,000 workers and dependents who will receive eligibility as a result of our change in definition under the disability benefit program.

The heading "Committee Bill Costs More for Less Protection Than Republican Proposal," which appears in the minority report seems worthy of comment. If it proves to be true, my friends on the minority do, indeed, have a remarkable program.

To overcome my initial skepticism, I requested a comment on the figures presented by the minority members from the chief actuary of the Social Security Administration. The melancholy reply was what I had feared. In the health care area, as in most other areas, you only get what you pay for. If the Republican proposal provides more, it has got to cost more. Or to put it in Mr. Myers' words:

Quite obviously, it is impossible for more benefits to be given under one proposal than another and, at the same time, for the first proposal to cost less than the second one. In brief, the errors in the analysis that is made in this section arise from comparing costs for groups of different size and from cost estimates that are on different bases.

Mr. Myers concludes that if the two programs are compared under similar assumptions, the Republican proposal would involve benefit disbursement costs some \$700 million more in the first full

year of operation than of the cost of the basic hospital insurance plan and the voluntary supplementary plan combined in the committee bill. Perhaps the relative costs of the programs can be best shown in percent of payroll—fully realizing that the minority plan and the committee's supplementary plan are to be financed by a combination of individual contribution and general revenue—and in monthly per capita costs:

	Long-range level (percent)	Monthly per capita (1st year)
Committee bill:		
Basic hospital.....	1.23	\$10
Voluntary supplementary.....	.49	5
Total.....	1.72	15
Republican bill:		
Voluntary.....		
Comprehensive.....	2.21	20

In order that the record reflect cost estimates on both the committee and minority proposals prepared under comparable assumptions, I would like to place in the Record a number of memorandums from Mr. Myers relative to their cost aspects:

MEMORANDUM OF APRIL 1, 1965

From: Robert J. Myers.

Subject: Appraisal of comparative cost estimates for health insurance proposals in "Separate Views of the Republicans" section of the House report on the Social Security Amendments of 1965.

On page 245 of the above report, a comparison is made of the estimated costs for the health insurance benefits under H.R. 6675 with those under the Republican proposal. The essence of the analysis made there is that "the committee bill costs more for less protection than the Republican proposal."

Quite obviously, it is impossible for more benefits to be given under one proposal than another and, at the same time, for the first proposal to cost less than the second one. In brief, the errors in the analysis that is made in this section arise from comparing costs for groups of different size and from cost estimates that are on different bases.

The section states that the cost for the first full year of operation (calendar year 1967) is \$3.42 billion for H.R. 6675, and \$2.95 billion for the Republican proposal. These figures are stated to be on the assumption of 80-percent participation in the programs. However, the figure of \$3.42 billion for H.R. 6675 consists of \$1.12 billion for the supplementary health insurance benefits plan on an 80-percent participation basis, and of \$2.30 billion for the hospital insurance plan that is on a virtually 100-percent basis.

I do not know the source of the last-mentioned figure since it does not relate either to contributions or to benefit payments plus administrative expenses, the former being estimated at \$2.60 billion and the latter being estimated at \$2.26 billion—both figures being shown on page 251. It is incorrect to use the contribution figure as a basis for the analysis because it involves a certain amount of advance funding. If, then, we use the figure for benefits and administrative expenses, it should be reduced by 20 percent so as to be on a comparable basis with that for the Republican proposal, which assumes 80 percent participation. On

this basis, the cost for H.R. 6675 is \$2.93 billion (80 percent or \$2.26 billion for the hospital insurance program, plus \$1.12 billion for the supplementary health insurance benefits program).

This adjusted cost figure of \$2.93 billion for H.R. 6675 is virtually the same as that shown in the section for the Republican proposal, even though the latter really has a higher benefit cost. The explanation for this difference is that the cost estimate given for the Republican proposal is not on the same conservative basis as that for H.R. 6675, both parts of which are estimated under high-cost assumptions. On the other hand, the cost estimate for the Republican proposal is an intermediate-cost estimate, which I made in my memorandum of February 26. A cost estimate for the Republican proposal that is comparable with the cost estimate for H.R. 6675 shows a total cost of \$3.60 billion, as compared with the \$2.90 billion shown in the report (the high-cost estimate being from my memorandum of February 9).

Thus, on a comparable basis, both as to degree of participation and as to actuarial cost assumptions, the Republican proposal has a higher cost for benefit payments and administrative expenses than H.R. 6675—as should properly be the case because of the more extensive benefit protection provided (for example, it includes benefits with respect to drugs, private-duty nursing, extremely long periods of hospitalization, etc.).

The cost analysis for the Republican proposal derives the "cost to be financed by taxpayers," which is the result of subtracting the premium contributions from the total cost of the program. The result would, of course, be different when comparable bases are used—for the reasons indicated previously. However, I question the significance of this concept because there is really little difference between the premium contributions made by persons currently eligible for the benefits and the contributions for hospital insurance made by workers, most of whom are under age 65, who will ultimately receive hospital benefit protection if they attain age 65.

The cost analysis in this section also derives a net cost figure assuming 100-percent participation. If the high-cost estimate basis is used, following the conservative financing approach underlying H.R. 6675, the total annual benefit cost would be \$4.55 billion. To obtain the net cost to general revenues, offset against this would be the premium contributions of \$1.25 billion and the recoupment of the tax revenue loss from medical deductions in the income tax of \$0.25 billion, or a net cost of \$3.05 billion—as compared with \$1.80 billion shown in this section. My figure does not include—as does the \$1.80 billion—any reduction in Federal costs for OAA and MAA, since the provisions therefor in the bill require that State and local government funds for public assistance programs should not be reduced over present levels. Accordingly, there would be no savings in Federal funds in this connection. It is proper to follow this procedure since the Republicans have stated that they support the amendments in H.R. 6675 relating to the Kerr-Mills program.

ROBERT J. MYERS.

MEMORANDUM OF APRIL 2, 1965

From: Robert J. Myers.

Subject: Cost estimate for financing the Republican proposal for health insurance benefits for persons aged 65 and over on a contributory social insurance basis.

This memorandum will present a cost estimate for financing the health insurance

benefits under the Republican proposal through a social insurance approach that would use the same earnings bases as those in H.R. 6675. The Republican proposal is contained in H.R. 4351 and companion bills. The cost estimate made here for that proposal is on the same conservative assumptions as those used for the cost estimate for the committee bill.

The estimated level cost of the benefit payments and administrative expenses of the hospital insurance provisions of the committee bill is 1.23 percent of taxable payroll, whereas the corresponding figure for the Republican proposal is 2.21 percent of taxable payroll. If the supplementary health insurance benefits provisions of the committee bill were on a compulsory basis like the hospital insurance provisions (instead of on a voluntary individual-election basis financed by premiums from the beneficiaries and matching Government contributions), the estimated level cost of these benefits, plus that for the hospital insurance provisions would be 172 percent of taxable payroll. Accordingly, the contribution rate schedule for the Republican proposal (combined with an earnings base of \$5,600 in 1966-70 and \$6,600 thereafter) would be as follows for the combined employer-employee rate, as compared with the corresponding schedule for the committee bill (showing both the schedule in the bill for the health insurance benefits and that which would be included if the supplementary health insurance benefits were also included on the same financing basis):

(In percent)			
Calendar year	Committee bill	Committee bill, plus SSB provisions	Republican proposal
1966.....	0.7	1.0	1.4
1967-70.....	1.0	1.4	1.9
1971-75.....	1.1	1.6	2.0
1976-80.....	1.2	1.7	2.2
1981-85.....	1.4	2.0	2.5
1986 and after.....	1.6	2.2	2.8

These schedules for the Republican proposal and for the supplementary health insurance benefits proposal are determined from the same cost and financing assumptions as that for the committee bill. The schedules would thus not only meet the cost of the benefit payments and administrative expenses, but also would build up moderate contingency funds. Furthermore, just as is the case with the committee bill, if the earnings base increases after 1971, and if all the other cost assumptions are realized, the contribution rates would not have to increase as much as is indicated in the foregoing schedules.

Under this financing basis, the Republican proposal would have contribution income of \$3.2 billion in calendar year 1966 and disbursements for benefits and administrative expenses of \$2.1 billion (assuming that benefit payments would first be available in July 1966). In calendar year 1967, contribution income would be \$5 billion, while disbursements for benefits and administrative expenses would be about \$4.5 billion.

The attached table shows the estimated progress of the trust fund that would develop under the foregoing contribution schedule under the financing basis and actuarial cost assumptions underlying the hospital insurance provisions of the committee bill.

ROBERT J. MYERS.

Estimated progress of health insurance trust fund under Republican proposal if financed in same manner as hospital insurance proposal in committee bill

[In millions]

Calendar year	Contributions	Benefit payments	Administrative expenses	Interest on fund	Balance in fund at end of year
1966	\$3,156	\$1,897	\$185	\$34	\$1,108
1967	4,964	4,254	296	34	1,556
1968	5,301	4,553	316	51	2,039
1969	5,470	4,866	338	66	2,371
1970	5,668	5,197	361	75	2,556
1971	6,321	5,531	385	84	3,045
1972	6,627	5,875	408	98	3,487
1973	7,180	6,230	433	114	4,118
1974	7,490	6,627	461	130	4,650
1975	7,758	6,966	484	142	5,100
1980	10,966	9,145	636	266	9,450
1985	12,568	11,828	822	425	13,801
1990	15,803	15,176	1,055	581	15,636

¹ Including administrative expenses incurred in 1965.

Now, Mr. Chairman, this program costs money. Let us not think for 1 minute that this or any other program can be provided without it costing money. I have been just a little bit concerned about what was said in the report of the minority—that they could do more and provide more benefits for more people for less money than the committee bill did. Very frankly, I do not think you can develop a program with benefits of the same value from the general funds of the Treasury or through the mechanism of a payroll tax and have, if the amount of benefits is exactly the same in either approach, one cost less than the other. It is beyond my comprehension that any of us today are brilliant enough to come forward with a method of providing more benefits to more people and having it cost less money. It just does not sound reasonable or logical to me.

In developing this comprehensive health insurance program for the aged the Committee on Ways and Means was mindful that a program is no better than its administration. The committee proposals reflect a conviction that the administrative challenges brought by this new program can be met by the combined efforts of voluntary organizations and the Government. The governmental part of this challenge will nevertheless remain large. It will fall mainly to the Social Security Administration. We believe that this agency's outstanding record for service and efficiency will be carried forward into the new program.

The Social Security Administration, however, will face a major job of advance planning and preparation to bring the health insurance programs into operation by next year. Extensive negotiations will be required to complete agreements and financial arrangements with fiscal intermediaries, insurance carriers, State agencies, and others. Broad-scale consultation will also be required with professional organizations representing the Nation's hospitals and others who furnish reimbursable health services. Operational policies and recordkeeping procedures will have to be worked out on a scope never before undertaken in the health field. This will entail, among other things, putting into the hands of 19 million aged people information about the two health insurance programs, answering inquiries on the benefits of the voluntary insurance plan,

setting up records for those who elect the plan, and preparing and delivering identification cards for all the eligible aged. In addition to this vast enrollment task, the Social Security Administration will have a tremendous job of taking and developing new claims in order to establish the basic eligibility of the aged who have been uninsured for cash benefits and from all others over 65 who have not yet applied for social security benefits. This will mean a doubling of the normal old-age and survivors disability insurance claims load for a single year, at the same time that changes in the disability insurance law and other social security changes will bring a heavy volume of additional activity into social security district offices.

I am sure the Social Security Administration will stand up to the challenge. I am sure, too, that when this bill becomes law the social security people, as they have so frequently demonstrated in the past, will lose no time in getting on with all the necessary preparations. They are well aware that carrying out the new programs and the improvements in the present one will demand all the talents and skills they can muster. This effort will require that all possible measures—in the Congress and in the Executive branch—be taken to assure that any obstacles that might get in the way of effective administration will be removed. It will be important, for example, that the needed supplemental appropriations, organizational changes, and greatly increased staffing take place just as soon as possible.

One very serious obstacle is the limitation on the number of people of supergrade rank that the Social Security Administration is now permitted. I am referring to the positions above the GS-15 grade. In this organization, which already operates the biggest insurance program of its kind in the world, pays over \$16 billion a year to nearly 20 million people, serves tens of thousands of people daily through a nationwide network of over 600 offices, and requires a staff of 36,000 people to conduct its operations there are today only 15 supergrade positions—2 of which are in the scientific and technical excepted group. This is 1 for every 2,400 employees. In comparison, the Railroad Retirement Board, conducting a somewhat similar program of much smaller scope, has 1 supergrade for every 211 employees—

more than 10 times the percentage of supergrades now permitted the Social Security Administration. The Internal Revenue Service has 1 supergrade for every 211 employees. The Civil Service Commission has 1 for every 136. The General Services Administration 1 for every 434, and the General Accounting Office 1 for every 156. None of these agencies has less than 5 times the percentage of supergrades allocated to the Social Security Administration. From these statistics it is clear that the allocation of higher level positions to direct the social security program has failed to keep pace with the rapid growth of the program. This obviously puts the Social Security Administration at a severe competitive disadvantage in its search for qualified and competent personnel not only with private industry but with other agencies of the Government.

This is the situation as it already exists. And now, in enacting this bill, we would be aggravating it seriously if no remedy is provided. If we expect—and we do expect—the Social Security Administration to carry out these new responsibilities in a manner befitting their importance and the needs and proper expectations of the American people, any unnecessary and inequitable handicaps upon the organization ought to be removed without delay. Effective carrying out of the provisions we are making for the health and security of the Nation's senior citizens, and for helping its widows and its orphans, is far too important, and too great a challenge to warrant risking impairment of the job by failing to allow the Social Security Administration enough higher level jobs to attract and retain the required human talents and skills.

As I have indicated, it would take a hundred supergrade jobs, considering the small allowance it now has and the necessary expansion this agency faces, to put it in a comparable position with the General Services Administration and nearly 200 to put it in a comparable position with the Internal Revenue Service. I would not undertake to say the exact number needed but I believe it is clear that the needed increase is large enough to call for special legislation. As one deeply concerned with the smooth and successful carrying out of the far-reaching programs we are acting on today, I hope the appropriate committees of the Congress will see their way clear to promptly consider such legislation which I believe is required to enable the administering agency to do the job in the way we and the people of the country want it done.

I must admit that the benefits in the committee bill cost money—yes, they cost money. Let us see what they cost. Let us see what we are doing in this bill to provide for those costs.

The health care program costs include those for the supplementary program, for the basic program, and for the medical assistance for the aged improvements. The basic program, which I have said is financed by the payroll tax device, will in the first full year of its operation, 1967, produce a cost of \$2,300 million on the basis of using high cost estimates, which we think is the conserva-

tive way to determine what something will cost when you have to provide a tax for it.

The voluntary supplementary health benefits program will have a cost out of the Federal Treasury, beginning July 1, 1966, of approximately \$600 million per year, while for the same period there will also be a cost of \$275 million for uninsured persons covered by the hospital insurance program.

The medical assistance for the aged liberalization of the program will cost about \$200 million per year.

The 7-percent across-the-board increase in the old-age and survivors disability insurance benefits payments will produce in the year 1966 additional benefit payments of \$1,400 million.

The child benefits to age 22 when in school will add an additional cost of \$195 million to the old-age survivors disability insurance trust funds in the first year.

The reduced age for widows will cost \$165 million out of those trust funds in the first year. But that is a disappearing item, because over the lifetime of the beneficiary it does not cost any additional amount to the system.

The transitional benefits at age 72 will cost, from the old-age survivors disability insurance trust fund \$140 million additional in the first year.

The changes we have made in the disability insurance program will cost \$105 million in the first year.

The changes we make with respect to the retirement test will cost \$65 million out of the old-age and survivors disability insurance trust funds in the first year.

That means a total from those two trust funds of \$1,905 million in the first year.

Public assistance amendments that increase the amount of Federal participation with the State in cash payments will cost \$150 million per year out of the general fund.

The changes we make in the exclusion of assistance payments to persons in TB and mental hospitals cost \$75 million per year.

The maternal and child health, crippled children part of it will cost \$60 million per year.

The OAA income exemption will have an annual cost of \$1 million.

Under the modified medical assistance for the aged definition, we have added \$2 million per year.

Mental retardation projects will have an annual cost of \$3 million.

That adds up to a total altogether out of the general fund of the Treasury of \$1,366 million per year.

Every dime of that is budgeted as it affects the upcoming fiscal year.

The \$875 million I referred to for payments from general funds with respect to the two health insurance programs, which will begin on July 1, 1966, is unbudgeted because we do not have the budget for the fiscal year 1967 as yet.

Now there is a further point which I should make here: the cost of administration.

Now, how do we propose to pay for the programs? We have increased both the maximum on the amount of earnings

that are subject to taxes from \$4,800 to \$5,600 on January 1, 1966, and then again, to \$6,600 on January 1, 1971, and the tax rates that would be applied to those earnings.

We have provided for increases in the tax rates over a period of years, as we have always done in the past, so that the actuary of the Department of Health, Education, and Welfare can tell us, "I can advise you that this program is actuarially sound." As he looks at it, over the forthcoming 75 years, this program of old-age and survivors disability insurance would only be out of balance by only about .08 percent of payroll.

Now as to the health part of the bill. We have worked out a separate tax and a separate trust fund. Let no one mislead you with statements, general in nature as they appear to be, and be not misled by the minority views expressed in the report that this separation is illusory.

Some statements have recently been made that I have, in effect, gone back on my previously expressed position that there must be separation between the cash benefits system and the proposed hospital benefits system. I emphatically state, here and now, that this is not the case. My conviction is that there must be separation and the bill I bring to you reflects this belief. For years I have maintained that the basic difference between the two types of benefits makes it essential that we have two separate systems. During many hours of questioning the Government witnesses before our committee, particularly the Chief Actuary, I brought out the different nature of the cost assumptions which underlie the hospital program as distinguished from the cash program. I pointed out that some assumptions which were conservative under one program had exactly the reverse effect when applied to the other program. Thus, as the committee drew up the bill, at every opportunity I urged that provisions be inserted which would provide meaningful separation between the two systems.

The minority members of the committee have written in the report that this is somewhat illusory and it was stated, at the Rules Committee, that what we have in the bill is just the same arrangement which exists under current law in respect to the disability insurance program and the old-age and survivors insurance program. I respectfully beg to differ. In respect to these two programs under existing law there is no separate tax, merely an allocation of revenues between two trust funds. The fact that this is merely an allocation is illustrated by the bill before you today which provides for a redistribution of the revenues from the combined old-age and survivors disability insurance tax. This new allocation, which will put the disability insurance fund on a sound actuarial basis to make up for some unfavorable cost experience in recent years, would not be possible as to hospital benefits under your committee's bill. Under H.R. 6675 any readjustment of revenue because of either unfavorable or favorable experience will have to be done by a change in the tax rate or earnings

base—or both—of the separate hospital insurance tax.

The hospital program will thus be financed from its own tax and there will be no shifting of funds—either way—from the old-age, survivors, and disability program.

Let me once again summarize the separation of program envisioned by this bill by reading from the report on page 48:

First, the schedules of tax rates for old-age, survivors, and disability insurance and for hospital insurance are in separate subsections of the Internal Revenue Code (unlike the situation for old-age and survivors insurance as compared with disability insurance, where there is a single tax rate for both programs, but an allocation thereof into two portions).

Second, the hospital insurance program has a separate trust fund (as is also the case for old-age and survivors insurance and for disability insurance) and, in addition, has a separate board of trustees from that of the old-age, survivors, and disability insurance system.

Third, the bill provides that income tax withholding statements (forms W-2) shall show the proportion of the total contribution for old-age, survivors, and disability insurance and for hospital insurance that is with respect to the latter.

Fourth, the hospital insurance program would cover railroad employees directly in the same manner as other covered workers, and their contributions would go directly into the hospital insurance trust fund and their benefit payments would be paid directly from this trust fund (rather than directly or indirectly through the railroad retirement system), whereas these employees are not covered by old-age, survivors, and disability insurance (except indirectly through the financial interchange provisions).

Fifth, the financing basis for the hospital insurance system would be determined under a different approach than that used for the old-age, survivors, and disability insurance system, reflecting the different natures of the two programs (by assuming rising earnings levels and rising hospitalization costs in future years instead of level-earnings assumptions and by making the estimates for a 25-year period rather than a 75-year one).

There is always a question of the degree to which to go in separation, but this is a separately enacted tax in an entirely separate section of the Internal Revenue Code. That is not true of the OASI and DI taxes. They are in the same section. They are levied as one tax, with authority to allocate a designated part of the total to the disability insurance trust fund. But there is a great difference in the enactment of a separate tax. There is also a separate trust fund.

The substitute plan proposed by the gentleman from Wisconsin [Mr. BYRNES] would not maintain a separateness of financing between his health insurance plan and the old-age and survivors insurance program. Instead the gentleman from Wisconsin [Mr. BYRNES] would draw some \$200 million a year from the old-age and survivors disability insurance trust fund to help finance his proposed health insurance benefits.

I can assure my colleagues who have had reservations in the past, as I have had reservations in the past about doing anything in any way that might jeop-

ardize the cash benefit program that has developed over the past 30 years and that has become such an important part of every elderly person's life, without any hesitation, without any equivocation, that there is not one single, solitary thing in this bill which would permit or allow for \$1 of the money which is set aside to go into the old-age and survivors disability insurance trust funds to ever get into the hospital insurance trust fund. It just cannot be done. Neither can the hospital insurance trust fund money be put over into the old-age and survivors disability insurance trust funds.

Call it illusory if you want to. We could have gone the full extent of separation. We could have put this hospital insurance program under the administration of an entirely new agency of Government. Then what would the critics on the outside have said, had we gone to the full extent? They would have accused the Committee on Ways and Means of having set up another elaborate 40,000-person bureaucracy. The expense of that would have been out of the question.

We could have completely separated the tax for purposes of filing the earnings record and paying the tax, but if we had done that, then they would have said that we had put the taxpayers to the unnecessary trouble of having to make two computations of taxes.

But to some it would not make any difference what was done; some argument would have been made that there would not be a separation.

This has been a bone of contention with me—and Members know it—that there must be a separation. I am thoroughly convinced that we have completed that separation in this bill.

Mr. Chairman, let me go back just a bit. On the basis of legislation that has been presented to the Ways and Means Committee, it does not appear that there is much doubt any more in the minds of many that we do have a problem of meeting medical care costs in the United States with respect to certain people in our population. These are our fathers and mothers and our grandparents who are living longer today than did their loved ones before them. We owe that to the great miracles which have been performed by medical science. But in the process of having performed those miracles, problems have resulted. Today's problems, as a result, are certainly greater in magnitude than those the generations before had, because of the greater length of time beyond retirement and before death, and because of the vicissitudes of illness of more and more of these people as a result of the length of their lives.

Thus the problem seems to be established in the minds of most. There is no argument on the part of my distinguished friend from Wisconsin [Mr. BYRNES] that there is this problem, for he introduces a bill to help, with respect to that problem, produced by himself, from that very great capacity that he possesses, and incorporating within his bill everything that is within the committee bill except with respect to the one matter of how do we finance the cost of taking care of this problem.

I have said consistently that I did not think that all of the medical costs that are incurred by those over 65 could be financed only through a payroll tax, because conceivably the payroll tax would be so high finally as to interfere with our capacity to compete in the world, with the payroll tax being charged as a cost of doing business. I have said repeatedly that we cannot run the risk of bankrupting the Federal Treasury once and for all by putting this entire cost upon the general fund of the Treasury. I think that the program has to be dealt with in a combination approach of two things: use of payroll tax and use of general fund revenues. That is what the committee has done. That is the only difference, apparently, that exists today between my distinguished friend who has offered his bill and the committee's proposition.

Just how do we finance the proposal? Because his proposition would be voluntary, with no compulsion under a payroll tax, it would be financed by the payment of the individual and from the general funds of the Treasury. In total, his plan would be financed just as our supplementary plan would be.

Now, how did we divide the health insurance provisions of H.R. 6675? Which did we put in which pocket and out of what account does it come and why? There are very, very important reasons why we propose to finance the benefits the way we do. It is the way that has been debated completely but which has been disregarded by the very people with whom we were trying to work. What did we do? We picked this single biggest element, namely, the cost of being in a hospital, and we financed that by the payroll tax to let the person during his working years, through small amounts of money paid per week, per month, or per year, make advance payments to that trust fund entirely on his own and from his employer and by the self-employed on their own account.

The CHAIRMAN. The time of the gentleman has expired.

Mr. MILLS. Mr. Chairman, I yield myself 5 additional minutes.

To take care of those expense during his working years so that when he reached retirement at 65 he would not then have to undertake the great burden of defraying the cost of the premium for that particular type of benefit. The proposal differs from H.R. 1. We took out of it every scintilla of payment to a physician—every scintilla of payment to a physician. Every safeguard has been placed so that no physician can be paid out of the trust fund created by the payment of a payroll tax. Now, what is it that you understood or that I understood had so greatly disturbed this great, wonderful medical profession that we have here in the United States? That we would finally, in time, put physicians' fees under a system where there would be a payroll tax, because they felt that if ever we did that, we would in time regulate the relationship between the physician and the patient by saying that this physician you can go to and this physician is not on our list; or by saying that we will pay out of this fund only this amount in the way of physicians'

fees and thus control and regulate physicians' fees.

Now, what have we done? In this committee bill in that respect we have done the same, identical thing that the gentleman from Wisconsin has done in his bill. And yet I understand that many of you have received telegrams as late as this morning urging you to vote for his motion to recommit because there is something unholy about the committee bill, whereas his bill, from their point of view, is perfect. How do we treat the physicians in both bills?

In both bills in the same identical way. Under both they would be paid out of the fund established under the voluntary enrollment program. In both instances the physicians would be paid from the same type of fund in the same, identical manner. And how would we pay them? In identically the same way. Not a payroll tax, but money contributed by the individual participant who would enroll after he got to be 65 and put up half of it, with the Treasury, out of its general funds, putting up the other half.

I thought that was exactly what it would take. I thought that was exactly what was required to remove this threat to medical practice in the United States and regardless of what anybody on the outside says to you, we have done it—we have done it. There is nobody in this Congress, I do not care who he is, who is any more cognizant or any more desirous of not changing the orderly practice of medicine than the gentleman speaking to you today. I am convinced in my own mind, as much as I have ever been convinced of anything, that there is not one solitary thing in this committee bill that carries any threat to the medical profession of this country that could not be said equally of the bill offered by the gentleman from Wisconsin [Mr. BYRNES]. And I do not think there is anything in either bill that jeopardizes the profession in any way. Why? How are we going to handle this thing? We are not going to deal with physicians direct; there is no intention to deal with them direct; there is no intention to tell them what they may charge their patients; we are not going to say to a patient, "You have got to go to Dr. X; you cannot go to Dr. Y."

How are we going to pay them? We are going to contract with somebody—Blue Shield, insurance companies, or other insurance carriers, and we express the desire that it be more than one. We should divide the program up somehow and let various organizations handle it—they are the ones who are going to pay the bills. But we even go to this extent because we recognize the sensitivity of this issue: We say, "We will leave to the election of the doctors, whether they are paid directly by the insurer, or whether the insurer pays the amount to the patient and the patient then pays the doctor."

If there is a doctor in your area who does not like the insurer and who does not want to have anything to do with it and does not want to carry its check to the bank, all he has to do is say to his patient, "You accept the benefit payment for this service, and you and I will settle the bill."

And, what if the doctor says that what the insurer is paying, before he ever operates, is not sufficient to satisfy him? He might say "My fee is so much, \$2,000, but this cost that you are indemnified against is only \$1,000." What then? We pay 80 percent of that \$1,000 to the patient, and the patient pays the doctor \$2,000, including the payment under the plan. If in the community where he lives, the sum of \$1,000 is the customary prevailing and reasonable fee against which we are indemnifying the patient, the doctor still makes the arrangement with his patient, or the patient makes it with his doctor to pay the difference.

Thus, Mr. Chairman, we have done everything that our minds were capable of conceiving to eliminate what appeared to us to be justifiable fears without these changes that we make.

Mr. Chairman, now very briefly—because it would take hours to discuss it all, but I have very briefly discussed even the medical portions of this bill—I would want you to know that finally it has been possible for us, after all these years, to develop a proposition that I could wholeheartedly and conscientiously, with every bit of the energy at my command, support. That has not been the case with reference to propositions in the past. Here, Mr. Chairman, I believe we have finally worked out a satisfactory and reasonable solution of an entire problem, not just a partial solution of a major problem. I feel that we have done it in a way, Mr. Chairman, that will commend it to the people for whom we do it and that they will realize that in spite of all that has been said in the past, in spite of all the ways that have been suggested in the past, finally the Committee on Ways and Means has produced the proper way to do it and that is the way that good legislation is developed.

Mr. Chairman, there is not a member of the Committee on Ways and Means whom I could not name today who has not made a major contribution to this bill by the inclusion of ideas of his own.

Mr. Chairman, where did we get the idea of the supplementary health benefits plan? Out of that fertile brain of the distinguished gentleman from Wisconsin [Mr. BYRNES].

Where did we get this idea and that idea? Out of the fertile brain of some other Democratic member or some other Republican member of the Committee on Ways and Means.

My distinguished friend, the gentleman from Virginia [Mr. BROYHILL], right at the last moment called to our attention a situation about which none of us had thought. However, as a result of the gentlemen's many years of experience on the Committee on the Post Office and Civil Service, he thought about it. It was fair and equitable, and we put it in.

Mr. Chairman, every member of the committee has made his contribution. On top of that, Mr. Chairman, the people in the Department of Health, Education, and Welfare worked with us faithfully from morning until night through all of these many days during which we have been in hearings and executive session and have made their contribution.

Mr. Chairman, those on the legislative counsel's staff of the House of Representatives and those who are staff members of both the joint committee and of the Committee on Ways and Means on both sides of the aisle have made their contribution.

Therefore, Mr. Chairman, I believe that there is sufficient ground within this bill for all of us to take pride and take credit.

I would suggest, therefore, that when tomorrow comes, we not toy with the bill by considering a motion to recommend, but that we take the bill as reported to the House from the Committee on Ways and Means and pass this bill as we have passed every other bill dealing with amendments to the Social Security Act in the past—by an overwhelming majority.

SUMMARY OF MAJOR PROVISIONS OF H.R. 6675

Mr. Chairman, I will include at this point for the convenience of the members a summary of the major provisions of H.R. 6675:

BRIEF OVERALL SUMMARY

The bill establishes two coordinated health insurance programs for persons 65 or over under the Social Security Act: (1) a basic plan providing protection against the costs of hospital and related care, financed through a separate payroll tax and trust fund; and (2) a voluntary supplementary plan covering payments for physicians' and other medical and health services financed through small monthly premiums by individual participants matched equally by a Federal Government general revenue contribution.

Undergirding the two new insurance programs would be a greatly expanded medical care program for the needy and the medically needy. This program would combine all the vendor medical provisions for the aged, blind, disabled, and families with dependent children now in five titles of the Social Security Act under a uniform program and matching formula in a single new title. The Federal matching share for cash payments for these needy persons would also be increased; services for maternal and child health, crippled children, and the mentally retarded would be expanded; a 5-year program of special project grants to provide comprehensive health care and services for needy children of school age, or preschool, would be authorized; and present limitations on Federal participation in public assistance to aged individuals in tuberculosis or mental disease hospitals would be removed under certain conditions.

With respect to the old-age, survivors, and disability insurance system the bill would increase benefits by 7 percent across the board with a \$4 minimum increase for a worker, cover certain currently uncovered occupations and wages (doctors, and income from tips), continue benefits to age 22 for certain children in school, provide social security tax exemption of self-employment income of certain religious groups opposed to insurance, provide actuarially reduced benefits for widows at age 60, and pay benefits, on a transitional basis, to certain persons currently 72 or over now ineligible; liberalize the definition for disability insurance benefits, increase the amount an individual is permitted to earn without suffering full deductions from benefits, revise the tax schedule, and increase the earnings counted for benefit and tax purposes so as to fully finance the changes made, and make certain changes in allocations to the old-age and survivors insurance and disability insurance trust funds.

MORE DETAILED SUMMARY

I. Health insurance for the aged

The bill would add a new title XVIII to the Social Security Act establishing two

related health insurance programs for persons 65 or over: (1) a basic plan providing protection against the costs of hospital and related care; and (2) a voluntary supplementary plan covering payments for physicians' services and other medical and health services to cover certain areas not covered by the basic plan.

The basic plan would be financed through a separate payroll tax and separate trust fund. Benefits for persons currently over 65 who are not insured under the social security and railroad retirement systems would be financed out of Federal general revenues.

Enrollment in the supplementary plan would be voluntary and would be financed by small monthly premium (\$3 per month initially) paid by enrollees and an equal amount supplied by the Federal Government out of general revenues. The premiums for social security and railroad retirement beneficiaries who voluntarily enroll would be deducted from their monthly insurance benefits. Uninsured persons desiring the supplemental plan would make the periodic premium payments to the Government. State welfare programs could arrange for uninsured assistance recipients to be covered.

A. Basic Plan

General description: Basic protection, financed through a separately identified payroll tax, would be provided against the costs of inpatient hospital services, posthospital extended care, posthospital home health services, and outpatient hospital diagnostic services for social security and railroad retirement beneficiaries when they attain age 65. The same protection, financed from general revenues, would be provided under a special transitional provision for essentially all people who are now aged 65, or who will reach age 65 before 1968, but who are not eligible for social security or railroad retirement benefits.

Benefits would be first effective on July 1, 1966 (except for services in extended care facilities which would be effective on January 1, 1967).

Benefits: The services for which payment would be made under the basic plan include—

1. Inpatient hospital services for up to 60 days in each spell of illness with the patient paying a \$40 deductible amount; hospital services would include all those ordinarily furnished by a hospital for its inpatients; however, payment would not be made for private duty nursing or for the hospital services of physicians except services provided by interns or residents in training under approved teaching programs;

2. Posthospital extended care (in a facility having an arrangement with a hospital for the timely transfer of patients and for furnishing medical information about patients) after the patient is transferred from a hospital (after at least a 3-day stay) for up to 20 days in each spell of illness; 2 additional days will be added to the 20 days for each day that the person's hospital stay was less than 60 days (up to a maximum of 80 additional days)—the overall maximum for posthospital extended care could thus be 100 days in each spell of illness;

3. Outpatient hospital diagnostic services with the patient paying a \$20 deductible amount for each diagnostic study (that is, for diagnostic services furnished to him by the same hospital during a 20-day period); if, within 20 days after receiving such services the individual is hospitalized as an inpatient in the same hospital, the deductible he paid for outpatient diagnostic services (up to \$20) would be credited against the inpatient hospital deductible (\$40); and

4. Posthospital home health services for up to 100 visits, after discharge from a hospital (after at least a 3-day stay) or extended care facility and before the beginning of a new spell of illness. Such a person must be

in the care of a physician and under a plan established by a physician within 14 days of discharge calling for such services. These services would include intermittent nursing care, therapy, and the part-time services of a home health aide. The patient must be homebound, except that when equipment is used the individual could be taken to a hospital or extended care facility or rehabilitation center to receive some of these covered home health services in order to get the advantage of the necessary equipment.

No service would be covered as posthospital extended care or as outpatient diagnostic or posthospital home health services if it is of a kind that could not be covered if it were furnished to a patient in a hospital.

A spell of illness would be considered to begin when the individual enters a hospital and to end when he has not been an inpatient of a hospital or extended care facility for 60 consecutive days.

The deductible amounts for inpatient hospital and outpatient hospital diagnostic services would be increased if necessary to keep pace with increases in hospital costs, but no such increase would be made before 1969. For reasons of administrative simplicity, increases in the hospital deductible will be made only when a \$5 change is called for and the outpatient deductible will change in \$2.50 steps.

Basis of reimbursement: Payment of bills under the basic plan would be made to the providers of service on the basis of the "reasonable cost" incurred in providing care for beneficiaries.

Administration: Basic responsibility for administration would rest with the Secretary of Health, Education, and Welfare. The Secretary would use appropriate State agencies and private organizations (nominated by providers of services) to assist in the administration of the program. Provision is made for the establishment of an Advisory Council which would advise the Secretary on policy matters in connection with administration.

Financing: Separate payroll taxes to finance the basic plan, paid by employers, employees, and self-employed persons, would be earmarked in a separate hospital insurance trust fund established in the Treasury. The amount of earnings (wage base) subject to the new payroll taxes would be the same as for purposes of financing social security cash benefits. The same contribution rate would apply equally to employers, employees, and self-employed persons and would be as follows:

	Percent
1966.....	0.35
1967-72.....	.50
1973-75.....	.55
1976-79.....	.60
1980-86.....	.70
1987 and thereafter.....	.80

The taxable earnings base for the health insurance tax would be \$5,600 a year for 1966 through 1970 and would thereafter be increased to \$6,600 a year.

The schedule of contribution rates is based on estimates of cost which assume that the earnings base will not be increased above \$6,600. If Congress, in later years, should increase the base above \$6,600, the tax rates established can be reduced under the cost assumptions underlying the bill.

The cost of providing basic hospital and related benefits to people who are not social security or railroad retirement beneficiaries would be paid from general funds of the Treasury.

B. Voluntary Supplementary Plan

General description: A package of benefits supplementing those provided under the basic plan would be offered to all persons 65 and over on a voluntary basis. Individuals who enrolled initially would pay premiums

of \$3 a month (deducted, where possible, from social security or railroad retirement benefits). The Government would match this premium with \$3 paid from general funds. Since the minimum increase in cash social security benefits for retired workers under the bill would be \$4 a month (\$6 a month for man and wife receiving benefits on the same earnings record), the benefit increase would fully cover the amount of monthly premiums.

Enrollment: Persons aged 65 before January 1, 1966, will have an opportunity to enroll in an enrollment period which begins on the first day of the second month after the month of enactment and ends March 31, 1966.

Persons attaining age 65 subsequent to December 31, 1965, will have enrollment periods of 7 months beginning 3 months before attaining 65.

In the future general enrollment periods will be from October to December 31, in each odd year. The first such period will be October 1 to December 31, 1967.

No person may enroll more than 3 years after close of first enrollment period in which he could have enrolled.

There will be only one chance to reenroll for persons who are in the plan but drop out, and reenrollment must occur within 3 years of termination of previous enrollment.

Coverage may be terminated (1) by the individual filing notice during enrollment period, or (2) by the Government, for nonpayment of premiums, after a grace period.

A State would be able to provide the supplementary insurance benefits to its public assistance recipients who are receiving cash assistance if it chooses to do so.

Benefits will be effective beginning July 1, 1966.

Benefits: The voluntary supplementary insurance plan would cover physicians' services, home health services, hospital services in psychiatric institutions, and numerous other medical and health services in and out of medical institutions.

There would be an annual deductible of \$50. Then the plan would cover 80 percent of the patient's bill (above the deductible) for the following services:

1. Physicians' and surgeons' services, whether furnished in a hospital, clinic, office, in the home, or elsewhere;

2. Hospital care for 60 days in a spell of illness in a mental hospital (180-day lifetime maximum);

3. Home health services (with no requirement of prior hospitalization) for up to 100 visits during each calendar year;

4. Additional medical and health services, whether provided in or out of a medical institution, including the following:

(a) Diagnostic X-ray and laboratory tests, electrocardiograms, basal metabolism readings, electroencephalograms, and other diagnostic tests;

(b) X-ray, radium, and radioactive isotope therapy;

(c) Ambulance services (under limited conditions); and

(d) Surgical dressings and splints, casts, and other devices for reduction of fractures and dislocations; rental of durable medical equipment such as iron lungs, oxygen tents, hospital beds, and wheelchairs used in the patient's home; prosthetic devices (other than dental) which replace all or part of an internal body organ; braces and artificial legs, arms, eyes, etc.

There would be a special limitation on outside-the-hospital treatment of mental, psychoneurotic, and personality disorders. Payment for such treatment during any calendar year would be limited, in effect, to \$250 or 50 percent of the expenses, whichever is smaller.

Administration by carriers, basis for reimbursement: The Secretary of Health, Education, and Welfare would be required, to the

extent possible, to contract with carriers to carry out the major administrative functions relating to the medical aspects of the program such as determining rates of payments under the program, holding and disbursing funds for benefit payments, and determining compliance and assisting in utilization review. No contract is to be entered into by the Secretary unless he finds that the carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent. The contract must provide that the carrier take necessary action to see that where payments are on a cost basis (to institutional providers of service), the cost is reasonable cost. Correspondingly, where payments are on a charge basis (to physicians or others furnishing noninstitutional services), the carrier must see that such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the other policyholders and subscribers of the carrier. Payment by the carrier for physicians' services will be made on the basis of a receipted bill, or on the basis of an assignment under the terms of which the reasonable charge will be the full charge for the service.

Financing: Aged persons who enroll in the supplemental plan would pay monthly premiums of \$3. Where the individual is currently receiving monthly social security or railroad retirement benefits, the premiums would be deducted from his benefits.

The Government would help finance the supplementary plan through a payment from general revenues of \$3 a month per enrollee. To provide an operating fund at the beginning of the supplementary plan, and to establish a contingency reserve, a Government appropriation would be available (on a repayable basis) equal to \$18 per aged person estimated to be eligible in July 1966 when the supplementary plan goes into effect.

The individual and Government contributions would be placed in a separate trust fund for the supplementary plan. All benefit and administrative expenses under the supplementary plan would be paid from this fund.

The provision in the income tax law which limits medical expense deductions to amounts in excess of 3 percent of adjusted gross income for persons under 65 would be reinstituted for persons 65 and over. Thus, provision is made for partial or full recovery of the Government contribution from enrolled persons with incomes high enough to require them to pay income taxes. A special deduction (for taxpayers who itemize deductions) of one-half of premiums for medical care insurance would be added, however, which would be applicable to taxpayers of all ages. Such special deduction could not exceed \$250 per year.

Premium rates for enrolled persons (and the matching Government contribution) would be increased from time to time in the event that costs rise, but not more often than once every 2 years. The premium rate for a person who enrolls after the first period when enrollment was open to him would be increased by 10 percent for each full year he stayed out of the program. It would also be increased for any period that he had terminated his coverage.

C. Costs of the Basic and Supplementary Plans

Benefits under both plans would first become payable for services furnished in July 1966, except for services in extended care facilities, for which benefits would first become payable in January 1967.

Basic plan: Benefits under the basic plan would be about \$1.0 billion for the 6-month period in 1966 and about \$2.2 billion in 1967. Contribution income for those years would

be about \$1.6 and \$2.6 billion, respectively. The costs for the uninsured (paid from general funds) would be about \$275 million per year for early years.

Supplementary plan: Costs of the supplementary plan would depend on how many of the aged enrolled.

If 80 percent of the eligible aged enrolled, benefit costs of the supplementary plan would be about \$195 million to \$260 million in the 6 months of 1966 and about \$765 million to \$1.02 billion in 1967. Premium income from enrollees for those years would be about \$275 and \$560 million, respectively. The matching Government contribution would be the same.

If 95 percent of the eligible aged enrolled, benefit costs of the supplementary plan would be about \$230 to \$310 million in 1966 and about \$905 million to \$1.22 billion in 1967. Premium income from enrollees for those years would be about \$325 and \$665 million, respectively. The Government contribution would be the same.

II. Improvement and extension of Kerr-Mills program

Purpose and scope: In order to provide a more effective Kerr-Mills program and to extend its provisions to other needy persons, the bill would establish a single and separate medical care program to replace the differing provisions for the needy which currently are found in five titles of the Social Security Act.

The new title (XIX) would extend the advantages of an expanded medical assistance program not only to the aged who are indigent but also to needy individuals on the dependent children, blind, and permanently and totally disabled programs and to persons who would qualify under those programs if in sufficient financial need.

Inclusion of the medically indigent aged would be optional with the States but if they are included comparable groups of blind, disabled, and parents and children must also be included if they need help in meeting necessary medical costs. Moreover, the amount and scope of benefits for the medically indigent could not be greater than that of recipients on the cash assistance programs.

The current provisions of law in the various public assistance titles of the act providing vendor medical assistance would terminate upon the adoption of the new program by the State but no later than June 30, 1967.

Scope of medical assistance: Under existing law, the State must provide "some institutional and noninstitutional care" under the medical-assistance-for-the-aged program. There are no minimum benefit requirements at all under the other public assistance vendor medical programs. The bill would require that by July 1, 1967, for the new program a State must provide inpatient hospital services, outpatient hospital services, other laboratory and X-ray services, skilled nursing home services, and physicians' services (whether furnished in the office, the patient's home, a hospital, or a skilled nursing home) in order to receive Federal participation in vendor medical payments. Other items of medical service would be optional with the States.

Eligibility: Improvements would be effected in the program for the needy elderly by requiring that the States must provide a flexible income test which takes into account medical expenses and does not provide rigid income standards which arbitrarily deny assistance to people with large medical bills. In the same spirit the bill provides that no deductible, cost sharing, or similar charge may be imposed by the State as to hospitalization under its program and that any such charge on other medical services must be reasonably related to the recipient's income or resources. Also important is the requirement that elderly needy people on the State

programs be provided assistance to meet the deductibles that are imposed by the new basic program of hospital insurance. Also where a portion of any deductible or cost sharing required by the supplementary voluntary program is met by a State program it must be done so in a manner reasonably related to the individual's income and resources. No income can be imputed to an individual unless actually available; and the financial responsibility of an individual for an applicant may be taken into account only if the applicant is the individual's spouse or child who is under age 21 or blind or disabled.

Increased Federal matching: The Federal share of medical assistance expenditures under the new program would be determined upon a uniform formula with no maximum on the amount of expenditures which would be subject to participation. This currently is done for the medical assistance for the aged program. The Federal share, which varies in relation to a State's per capita income, would be increased over current medical assistance for the aged matching so that States at the national average would receive 55 percent rather than 50 percent, and States at the lowest level could receive as much as 83 percent as contrasted with 80 percent under existing law.

In order to receive any additional Federal funds as a result of expenditures under the new program, the States would need to continue their own expenditures at their present rate. For a specified period, any State that did not reduce its own expenditures would be assured of at least a 5-percent increase in Federal participation in medical care expenditures. As to professional medical personnel, the bill would provide a 75-percent Federal share as compared with the 50-50 Federal-State sharing for other administrative expenses.

Administration: The State agency administering the new program would have to be the same as that administering the old-age assistance program. As some States have done under existing law, such an agency could delegate its function relating to the medical aspects of the program to the State health agency. The bill specifically provides as a State plan requirement that cooperative agreements be entered into with State agencies providing health services and vocational rehabilitation services looking toward maximum utilization of these services in the provision of medical assistance under the plan.

Effective date: January 1, 1966.

Cost: It is estimated that the new program will increase the Federal Government's contribution about \$200 million in a full year of operation over that in the programs operated under existing law.

III. Child health program amendments

Maternal and child health and crippled children: The bill would increase the amount authorized for maternal and child health services over current authorizations by \$5 million for fiscal year 1966 and by \$10 million in each succeeding fiscal year, as follows:

Fiscal year	Existing law	Under bill
1966	\$40,000,000	\$45,000,000
1967	40,000,000	50,000,000
1968	45,000,000	55,000,000
1969	45,000,000	55,000,000
1970 and thereafter	50,000,000	60,000,000

The authorizations for crippled children's service would be increased by the same amounts. Such increases would assist the States, in both these programs, in moving toward the goal of extending services with a view of making them available to children in all parts of the State by July 1, 1975.

Crippled children-training personnel: The bill would also authorize \$5 million for the

fiscal year 1967, \$10 million for fiscal 1968, and \$17.5 million for each succeeding fiscal year to be for grants to institutions of higher learning for training professional personnel for health and related care of crippled children, particularly mentally retarded children and children with multiple handicaps.

Health care for needy children: A new provision is added authorizing the Secretary of Health, Education, and Welfare to carry out a 5-year program of special project grants to provide comprehensive health care and services for children of school age, or for preschool children, particularly in areas with concentrations of low-income families. The grants would be to State health agencies, to the State agencies administering the crippled children's program, to any school of medicine (with appropriate participation by a school of dentistry), and any teaching hospital affiliated with such school, to pay not to exceed 75 percent of the cost of the project. Projects would provide screening, diagnosis, preventive services, treatment, correction of defects, and aftercare, including dental services, for children in low-income families.

An appropriation of \$15 million would be authorized for the fiscal year ending June 30, 1966; \$35 million for the fiscal year ending June 30, 1967; \$40 million for the fiscal year ending June 30, 1968; \$45 million for the fiscal year ending June 30, 1969; and \$50 million for the fiscal year ending June 30, 1970.

Mental retardation planning: This title would authorize grants totaling \$2,750,000 for each of 2 fiscal years—the fiscal year ending June 30, 1966, and the fiscal year ending June 30, 1967. The grants would be available during the year for which the appropriation is authorized and during the succeeding fiscal year until June 30, 1968. They are for the purpose of assisting States to implement and follow up on plans and other steps to combat mental retardation authorized under section 1701 of the Social Security Act.

IV. Old-age, survivors, and disability insurance amendments

Benefits

1. Seven percent, across-the-board benefit increase in old-age, survivors, and disability insurance benefits: The bill provides a 7-percent, across-the-board benefit increase, effective retroactively beginning with January 1965, with a minimum increase of \$4 for retired workers age 65 and older. These increases will be made for the 20 million social security beneficiaries now on the rolls.

Monthly benefits for workers who retire at or after 65 would be increased to a new minimum of \$44 (now \$40) and to a new maximum of \$135.90 (now \$127). In the future, creditable earnings under the increase in the contribution and benefit base to \$5,600 a year (now \$4,800) would make possible a maximum benefit of \$149.90.

The maximum amount of benefits payable to a family on the basis of a single earnings record would be related to the worker's average monthly earnings at all earnings levels. Under present law, there is a \$254 limit on family benefits which operates over a wide range of average monthly earnings. Under the bill, until 1971, the family maximum would be \$312.

Under the second-step increase in the wage base to \$6,600 to be effective in 1971, also provided in the bill, the worker's primary insurance amount would range from a minimum of \$44 to a future possible maximum of \$167.90 a month. Maximum family benefits up to \$368 would also be payable.

2. Payment of child's insurance benefits to children attending school or college after attainment of age 18 and up to age 22: The bill includes the provision adopted by both House and Senate last year which would continue to pay a child's insurance benefit until the child reaches age 22, provided the child

is attending public or accredited schools, including a vocational school or a college, as a full-time student after he reaches age 18. Children of deceased retired, or disabled workers would be included. No mother's or wife's benefits would be payable on the basis of a child who has attained age 18 but is in school.

This provision will be effective January 1, 1965. It is estimated that 295,000 children will be able to receive benefits for a typical school month in 1965 as a result of this provision.

3. Benefits for widows at age 60: The bill would provide the option to widows of receiving benefits beginning at age 60 with the benefits payable to those who claim them before age 62 being actuarially reduced to take account of the longer period over which they will be paid. Under present law, full widow's benefits and actuarially reduced worker's and wife's benefits are payable at age 62.

This provision, adopted by both Houses last year, would be effective for the second month after the month of enactment. It is estimated that 185,000 widows will be able to get benefits immediately under this provision.

4. Amendment of disability program: (a) Definition: The bill would eliminate the present requirement that a worker's disability must be expected to result in death or to be of long-continued and indefinite duration, and instead provide that an insured worker would be eligible for disability benefits if he has been totally disabled throughout a continuous period of at least 6 calendar months. Benefits payable by reason of this change would be paid for the second month following the month of enactment.

(b) Waiting period: The waiting period during which an individual must be under a disability prior to entitlement to benefits is reduced by 1 month by the bill. It provides that disability benefits would be payable beginning with the last month of the 6-month waiting period rather than with the first month after the 6-month waiting period as under existing law. This change would be applicable to all cases in which the last month of the waiting period occurs after the month of enactment.

It is estimated some 155,000 disabled workers and dependents will be benefited by these provisions.

Certain changes are also made in the provision terminating disability benefits and waiving subsequent waiting periods so as to make them more restrictive when applied to shorter term disabilities.

(c) Entitlement to disability benefits after entitlement to benefits payable on account of age: Under the bill, a person who becomes entitled before age 65 to a benefit payable on account of old age could later become entitled to disability insurance benefits.

(d) Allocation of contribution income between OASI and DI trust funds: Under the bill, an additional one-fourth of 1 percent of taxable wages and three-sixteenths of 1 percent of taxable self-employment income would be allocated to the disability insurance trust fund, bringing the total allocation to three-fourths of 1 percent and nine-sixteenths of 1 percent, respectively, beginning in 1966.

5. Benefits to certain persons at age 72 or over: The bill would liberalize the eligibility requirements by providing a basic benefit of \$35 at age 72 or over to certain persons with a minimum of three quarters of coverage which can be acquired at any time since the beginning of the program in 1937. To accomplish this, a new concept of "transitional insured" status is provided. Present law requires a minimum of six quarters of coverage in employment or self-employment.

(a) Men and women workers: The concept of "transitional insured" status which would make an individual eligible for an old-age

or wife's benefit provides that the oldest workers will receive benefits with only three quarters of coverage, under the bill. These three quarters may have been acquired at any time since the inception of the program in 1937. For those who are not quite so old, the quarters of coverage requirement would increase until the requirement merges with the present minimum requirement of six quarters.

The following table illustrates the operation of the "transitional insured" status provision for workers:

Workers benefits¹

Men		Women	
Age (in 1965)	Quarters of coverage required	Age (in 1965)	Quarters of coverage required
76 or over	3.	73 or over	3.
75	4.	72	4.
74	5.	71	5.
73 or younger	6 or more.	70 or younger	6 or more.

¹ Benefits will not be payable, however, until age 72.

Insured status provisions with respect to widow's benefits as to quarters of coverage required

Year of husband's death (or attainment of age 65, if earlier)	Present quarters required	Proposed quarters required for widow attaining age 72 in—		
		1966 or before	1967	1968
1954 or before	6	3	4	5
1955	6	4	4	5
1956	6	5	5	5
1957 or after	6 or more	6 or more	6 or more	6 or more

(c) Basic benefits: Men and women workers who would be eligible under the above-described provisions for workers would receive a basic benefit of \$35 a month. A wife, aged 72 or over (and who attains that age before 1969) would receive one-half of this amount, \$17.50. No other dependents' basic benefits would be provided under these provisions.

Widows would receive \$35 a month under the above-described provision.

These provisions would become effective for the second month after the month of enactment, at which time an estimated 355,000 persons would be able to start receiving benefits.

6. Retirement test: The bill liberalizes the social security earned income limitation so that the uppermost limit of the "band" of \$1 reduction in benefits for \$2 in earnings is raised from \$1,700 to \$2,400. Under existing law the first \$1,200 a year in earnings is wholly exempted, and there is a \$1 reduction in benefits for each \$2 of earnings up to \$1,700 and \$1 for \$1 above that amount. The bill would increase the \$1 for \$2 "band" so that it would apply between \$1,200 and \$2,400, with \$1 for \$1 reductions above \$2,400. This change is effective as to taxable years ending after 1965.

The bill also exempts certain royalties received in or after the year in which a person reaches age 65 from copyrights and patents obtained before age 65 from being counted as earnings for purposes of this test effective as to taxable years beginning after 1964.

7. Wife's and widow's benefits for divorced women: The bill would authorize payments of wife's and widow's benefits to the divorced wife aged 62 or over of a retired, deceased, or disabled worker if she had been married to the worker for at least 20 years before the date of the divorce and if her divorced husband was making (or was obligated by a court to make) a substantial contribution to her support when he became entitled to benefits, became disabled, or died.

(b) Widows: Any widow who is age 72 or over in 1966, if her husband died or reached age 65 in 1954 or earlier, can get a widow's benefit if her husband had at least three quarters of coverage. Present law requires six quarters.

If the husband died or reached 65 in 1955, the requirement is four quarters. If he died or reached 65 in 1956, the requirement would be five quarters. If he died or reached 65 in 1957 or later, the minimum requirement would be six quarters, the same as present law.

For widows reaching age 72 in 1967 and 1968, there is a "grading in" of coverage requirement of four or five quarters of coverage, respectively. Widows reaching age 72 in 1969 or after would be subject to the requirements of existing law of six or more quarters of coverage.

The table below sets forth the requirements as to widows:

The bill would also provide that a wife's benefits would not terminate when the woman and her husband are divorced if the marriage has been in effect for 20 years. Provision is also made for the reestablishment of benefit rights for a widow or a wife who remarries and the subsequent marriage lasts less than 20 years. These changes are effective as to second month following month of enactment.

8. Adoption of child by retired worker: The bill would change the provisions relating to the payment of benefits to children who are adopted by old-age insurance beneficiaries to require that as to any adoption after the worker becomes entitled to an old-age benefit (1) the child be living with the worker (or adoption proceedings have begun) in or before the month when application for old-age benefits is filed; (2) the child be receiving one-half of his support for a year before the worker's entitlement; and (3) the adoption be completed within 2 years after the worker's entitlement.

COVERAGE

The following coverage provisions (contained in the House-passed bill last year) were included:

1. Physicians and interns: Self-employed physicians would be covered for taxable years ending after December 31, 1965. Interns would be covered beginning on January 1, 1966, on the same basis as other employees working for the same employer.

2. Farmers: Provisions of existing law with respect to the coverage of farmers would be amended to provide that farm operators whose annual gross earnings are \$2,400 or less (instead of \$1,800 or less as in existing law) can report either their actual net earnings of 66⅔ percent (as in present law) of their gross earnings. Farmers whose annual gross earnings are over \$2,400 would report their actual net earnings if over \$1,600, but if actual net earnings are less than \$1,600, they may instead report \$1,600. (Present law provides that farmers whose annual gross earnings are over \$1,800 report their actual

net earnings if over \$1,200, but if actual net earnings are less than \$1,200, they may report \$1,200.) This change would be effective for taxable years beginning after December 31, 1965.

3. Cash tips: Coverage of cash tips received by an employee in the course of his employment as wages would be provided, effective as to tips received after 1965.

(a) Reporting of tips: The employee would be required to report to his employer in writing the amount of tips received and the employer would report the employee's tips along with the employee's regular wages. The employee's report to his employer would include tips paid to him through the employer as well as those received directly from customers of the employer. Tips received by an employee which do not amount to a total of \$20 a month in connection with his work for any one employer would not be covered and would not be reported.

(b) Tax on tips: The employer would be required to withhold social security taxes only on tips reported by the employee to him. Unlike the provision in last year's House bill, the employer would be required to withhold income tax on such reported tips. The employer would be responsible for the social security tax on tips only if the employee reported the tips to him within 10 days after the end of the month in which the tips were received. The employer will be permitted to gear these new procedures into his usual payroll periods. The employer would pay over his own and the employee's share of the tax on these tips and would include the tips with his regular reports of wages. If at the time the employee report is due (or, in cases where the report is made earlier—if between the making of the report and the time it is due), the employer does not have unpaid wages or remuneration of the employee under his control sufficient to cover the employee's share of the social security tax applicable to the tips reported, the employee will pay his share of the tax with his report.

If the employee does not report his tips to his employer within 10 days after the end of the month involved, the employer would have no liability. In such a case the employee alone would be liable not only for the amount of the employee tax but also an additional amount equal to the employer tax.

4. State and local government employees: Alaska and Kentucky would be added to the list of States which may cover State and local government employees under the divided retirement system provision. This provision allows current employees desiring to do so to elect coverage; future employees are covered compulsorily.

Another opportunity would be provided, through 1966, for the election of coverage by people who originally did not choose coverage under the divided retirement system provision.

Coverage would be made available to certain hospital employees in California whose positions were removed from a State or local government retirement system.

New coverage provisions in the bill (not contained in last year's bill) are:

1. District of Columbia employees: Coverage would be extended to employees of the District of Columbia who are not covered by a retirement system. About 600 substitute teachers would be involved. The District of Columbia Commissioners also could shift the coverage of temporary and intermittent employees from the civil service retirement system to social security. The earliest date on which coverage could become effective would be the first day of the calendar quarter following the calendar quarter of enactment.

2. Exemption of certain religious sects: Members of certain religious faiths may be exempt from social security self-employment taxes and coverage upon application which would be accompanied by a waiver of benefit rights. An individual eligible for

the exemption must be a member of a recognized religious sect (or a division of a sect) who is an adherent of the established teachings of such sect by reason of which he is conscientiously opposed to acceptance of the benefits of any private or public insurance, making payments in the event of death, disability, old-age, or retirement, or making payments toward the cost of, or providing services for, medical care (including the benefits of any insurance system established by the Social Security Act). The Secretary of Health, Education, and Welfare must find that such sect has such teachings and has been in existence at all times since December 31, 1950, and that it is the practice for members of such sect to make provision for their dependent members which, in the Secretary's judgment, is reasonable in view of their general level of living. The exemption for previous years (taxable years ending prior to December 31, 1965) must be filed by April 15, 1966. The exemption would be effective as early as taxable years beginning after December 31, 1950.

3. Nonprofit organizations: Nonprofit organizations could provide coverage for em-

ployees retroactively for up to 5 years (1 year under present law); also, validation of certain erroneously reported wages would be permitted.

MISCELLANEOUS

1. Filing of proof: Extends indefinitely the period of filing of proof of support for dependent husbands, widowers and parent's benefits, and lump-sum death payments where good cause exists for failure to file within initial 2-year period.

2. Automatic recomputation of benefits: The benefits of people on the rolls would be recomputed automatically each year to take account of any covered earnings that the worker might have had in the previous year that would increase his benefit amount. Under existing law there are various requirements, including filing of an application and earnings of over \$1,200 a year after entitlement.

3. Military wage credits: Replaces present provision authorizing reimbursement of trust funds out of general revenue for gratuitous social security wage credits for servicemen so that such payments will be spread over the next 50 years (now 10 years).

Number of persons immediately affected and amount of additional benefits in the full year 1966

Percent benefit increase \$4 minimum in primary benefits)	20 million persons	\$1.4 billion.
Child's benefit to age 22 if in school	295,000 children	\$195 million.
Reduced age for widows	185,000 widows	\$165 million (no long-range charge to system because of actuarial reduction).
Reduction in eligibility requirement for certain persons aged 72 or over.	355,000 persons	\$140 million.
Liberalization of disability definition	155,000 workers, and dependents.	\$105 million.
Liberalization of retirement test		\$65 million.

FINANCING OF OASDI AMENDMENTS

The benefit provisions of the bill are financed by (1) an increase in the earnings base from \$4,800 to \$5,600 (effective January 1, 1966), and \$6,600 (effective 1971), and (2) a revised tax rate schedule.

The tax rate schedule under existing law and revised schedule provided by the bill for OASDI programs follow:

Years	[In percent]		Self-employed rate	
	Employer-employee rate (each)		Present law	
	Present law	Bill	Present law	Bill
1965	3.625	3.625	5.4	5.4
1966	4.125	4.0	6.2	6.0
1967	4.125	4.0	6.2	6.0
1968	4.625	4.0	6.9	6.0
1969-72	4.625	4.4	6.9	6.6
1973 and after	4.625	4.8	6.9	7.0

V. Public assistance amendments

1. Increased assistance payments: The Federal share of payments under all State public assistance programs is increased a little more than an average of \$2.50 a month for the needy aged, blind, and disabled and an average of about \$1.25 for needy children, effective January 1, 1966. This is brought about by revising the matching formula for the needy aged, blind, and disabled (and for the adult categories in title XVI) to provide a Federal share of \$31 out of the first \$37 (now twenty-nine thirty-fifths of the first \$35) up to a maximum of \$75 (now \$70) per month per individual on an average basis. The bill revises matching formula for aid to families with dependent children so as to provide a Federal share of five-sixths of the first \$18 (now fourteen-sevenths of the first \$17) up to a maximum of \$32 (now \$30). A provision is included so that States will not receive additional Federal funds except to the extent they pass them on to individual recipients. Effective January 1, 1966. Cost: About \$150 million a year.

2. Tubercular and mental patients: Removes exclusion from Federal matching in

old-age assistance and medical assistance for the aged programs (and for combined program, title XVI) as to aged individuals who are patients in institutions for tuberculosis or mental diseases or who have been diagnosed as having tuberculosis or psychosis and, as a result, are patients in a medical institution. Requires as condition of Federal participation in such payments to, or for, mental patients certain agreements and arrangements to assure that better care results from the additional Federal money. Provides that States will receive no more in Federal funds under this provision than they increase their expenditures for mental health purposes under public health and public welfare programs. Also removes restrictions as to Federal matching for needy blind and disabled who are tubercular or psychotic and are in general medical institutions. Effective January 1, 1966. Cost: About \$75 million a year.

3. Protective payments to third persons: Adds a provision for protective payments to third persons on behalf of old-age assistance recipients (and recipients on combined title XVI program) unable to manage their money because of physical or mental incapacity. Effective January 1, 1966.

4. Earnings exemption under old-age assistance: Increase earnings exemption under old-age assistance program (and for aged in the combined program) so that a State may, at its option, exempt the first \$20 (now \$10) and one-half of the next \$60 (now \$40) of a recipient's monthly earnings. Effective January 1, 1966. Cost: About \$1 million first year.

5. Definition of medical assistance for aged: Modifies definition of medical assistance for the aged so as to allow Federal sharing as to old-age assistance recipients for the month they are admitted to or discharged from a medical institution. Effective July 1, 1965. Cost: About \$2 million.

6. Retroactive benefit increase: The bill adds provision which allow the States to disregard so much of the OASDI benefit increase as is attributable to its retroactive effective date.

7. Economic Opportunity Act earnings exemption: The bill also provides a grace pe-

riod for action by States that have not had regular legislative sessions, whose public assistance statutes now prevent them from disregarding earnings of recipients received under the Economic Opportunity Act.

8. Judicial review of State denials: The bill provides for judicial review of the denial of approval by the Secretary of Health, Education, and Welfare of State public assistance plans and amendments and of his action under such programs for noncompliance with State plan conditions in the Federal law.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield myself 15 minutes.

(Mr. BYRNES of Wisconsin asked and was given permission to revise and extend his remarks.)

Mr. BYRNES of Wisconsin. Mr. Chairman, I regret that we must consider a bill of this proportion, dealing as it does with such sensitive and far-reaching matters, all in one bill. As a result, we are required to consider the good and the bad, with no opportunity to separate, as it were, the wheat from the chaff. Instead of considering one single bill, Mr. Chairman, we should be considering at a minimum two separate bills. The chairman of the Committee on Ways and Means has suggested that it could even be divided further when he states there are four monumental sections to this omnibus bill we are considering. I would have been well pleased and well satisfied if he would have earlier limited it to two and said: "Let us consider two separate monumental aspects of this bill. First. That part making necessary changes in the old-age, survivors, and disability insurance section, the cash benefit program, and the various welfare programs; and, second, another bill dealing with the medical care proposals." It seems to me that the House and its Members should have some opportunity to really work their will on this legislation.

The medical provisions should stand or fall on their own merits, and the amendments to the old-age, survivors, and disability insurance system, the cash benefit program, should stand or fall on the merits of those amendments. But as it is we are forced to accept the bad with the good, or reject the good with the bad.

This is not, in my judgment, a good way for a democratic body—and I use a small "d"—to function. It is not the way to get a full expression of the will of the House of Representatives.

I proposed earlier this year when the committee first began its consideration of this matter, that we consider and consider promptly amendments to the old-age and survivors disability insurance system and the other welfare programs, and get that on its way. We had already done the groundwork on that. We had passed in this House last year a bill providing necessary amendments and changes. It had gone through the Senate, it had been practically through conference, we could have acted speedily, and it could have been enacted into law long before this. In fact, I might review just a little history to point out that the amendments to the old-age survivors disability insurance sections of this bill could have been passed last fall if the word had not come down, and

the insistence made that "Oh, no, you have to tie all of these together because of the fear that the medical part of this program could not stand on its own merits."

Let me point out this at the very beginning, that we on the committee, Democrats and Republicans alike, are in general agreement with respect to those provisions in the bill as reported by the committee relating to the old-age and survivors system, the disability system, and even as far as the Kerr-Mills system is concerned. That is not to say we have agreed on everything that is in the bill today, but generally we could have accepted them and they could have passed this House without a dissenting vote if we had limited it to that.

Yes, and we are in agreement in the committee, Democrats and Republicans alike, that our aged people face a problem with respect to providing for their medical care. We acknowledged that as far back as 1950, when we authorized the Federal Government to participate in subsidizing the benefit payments made by States to certain of its aged people who were in need.

We recognized it again when we enacted in the first instance the Kerr-Mills bill, and we still recognize that this is a problem of our older people.

We all feel, Democrats and Republicans alike, that something should be done, that action is called for. Our difference, and it is an important difference, is as to how. How do we do it? How do we meet the problems of these people in a way that is best for them and is best for this Nation and in the best interests of all of our people?

Let me, in my discussion of the bill before us and the issue before us, say a few words about the changes that have been made in the basic Social Security Act. I am most pleased at some of the changes that are made because they are changes that I have been advocating for some time. We finally are moving in this bill to correct what I consider to be some very serious inequities and some injustices.

I would mention first the benefit level. It was last year when this matter of increasing the level of benefits under the old-age and survivors and disability insurance was under consideration that I proposed, and in fact, moved in the committee that the benefit level be increased by 7 percent. We were told at that time by the administration, and this position was supported by the majority on the committee, that it had to be held to a 5-percent increase and that it had to be held there in order to accommodate a medical care program under the social security system.

Do not forget that history because it is important to remember when the proponents of the committee bill say the medical program can have no effect on the cash benefits, that we do not have to worry about superimposing a medical care program on the old-age and survivors insurance system.

It was as recent as last year that we were told—yes; the cost of living has increased 7 or 8 percent since we last increased the cash benefit level, but you cannot increase benefits by 7 percent and

still have enough of the payroll tax left to finance a medical care program under social security.

That, my friends, is what is also going to happen again in the future if we tie a hospitalization program to the old-age and survivors insurance system, as is done in this bill as reported by the committee.

There is going to come a day when you will recognize the need for increased cash benefits in that program and you will be foreclosed from doing so because you will have preempted the payroll tax and the source of revenue from that source for the purposes of medical care, and you will not have sufficient left to do what should be done with respect to cash benefits.

I am pleased at the change that is involved in this bill over the bill last year, and I am pleased by the 7-percent increase.

There is a provision in this bill and the chairman has referred to it, of paying benefits on a transitional basis to certain persons 72 years of age and over who are not now eligible for cash benefits. We have had, in my judgment, a very serious inequity in the old age and survivors insurance system in that we completely ignored the plight of many of our older people, a large percentage of whom are widows, who because they were born too soon, you might say, or because the Congress acted too late do not receive the benefits of the old age and survivors insurance system.

In 1960 I first introduced in the 80th Congress a bill to provide benefits for these people. I am most pleased today to see the committee at least in part moving to solve this problem by the provision that has been added to the bill to include and provide benefits for those over 72 years of age in certain circumstances.

Another item that was of some interest to me and which I encouraged the committee to include—and I think I can at least take some credit for having it included—is the item providing for increasing the amount an individual is permitted to earn without losing benefits. That was not in the bill when it was sent to us by the administration. It was not in the King-Anderson bill and it was not in the preliminary draft of the bill that was submitted to the committee prior to the final action. But we did insert in the bill, during the latter days, this provision increasing the amount an individual can earn and still not lose his cash benefits.

Then also there is a provision that I would point out that liberalizes the income treatment for the self-employed farmer. This corrects a problem I brought to the attention of the committee last year.

Then there is another provision that I think we all should be acquainted with because it is of considerable significance and also moves toward the correction of problem which I have felt existed in our tax laws through the years. This is not an item relating specifically to our aged and to those over 65. This is an item that relates to all of our people. It is the provision which will permit a person no matter what his age, in determin-

ing his income tax and his tax liability, to deduct 50 percent of the cost of the premiums for a health insurance policy up to a maximum deduction of \$250 without being limited by the 3-percent floor. This provision moves in the direction of encouraging our people to provide insurance against the risks of medical costs.

I first proposed legislation to remedy this problem in 1962, in the 87th Congress. I believe it will be of considerable help and encouragement toward greater expansion of private insurance for the mass of our population, and therefore a move in the right direction.

Now let me come to the parts of the bill which are in controversy, to that part of the bill which the proponents are unwilling to let stand on its own feet and rise or fall on its own merits, but which they have to tie to the now controversial amendments to the Social Security Act.

Perhaps I could best discuss this aspect of the bill and the problem by pointing out in the first instance what I would propose to replace the provisions of the bill as reported by the committee relating to medical care for the aged over 65.

The bill I propose, which I have introduced, includes all of the social security amendments, all of the public welfare amendments, all of the amendments to the Kerr-Mills Act, to which I have, however, added specifically the option for the States to adopt the eldercare program. The only difference between the bill I have proposed and will offer as a substitute and the bill as reported by the committee is in the approach to the problem of health insurance for the aged.

The substitute bill provides a program of health insurance which is admittedly the most comprehensive available today. The substitute adopts the approach used by the private insurance industry and it is patterned after the system of insurance that we have provided for our own Federal employees. The benefits are patterned on the high option of the Government-wide indemnity contract negotiated between the Civil Service Commission and private carriers for the benefit of Federal employees. It makes no distinction between medical services in the hospital or out of the hospital and it thus avoids placing unnecessary reliance on hospitalization, as I feel the committee bill does, which is the area admittedly where the costs are the greatest and the most likely to rise in the future.

The program is also patterned after the program we make available to our Federal employees in that we provide for a sharing of premium costs. The individual participates on a voluntary basis. He has the choice as to whether he wants to take the insurance policy or not. He pays a part of the premium costs. The Federal Government pays the balance of the premium costs.

For parts 1 and 2 of title I of the committee bill—these are the sections which provide for the hospitalization and related medical services—I substitute a single comprehensive program of Federal insurance. The program incorporates the medical program of the committee bill into a single package of bene-

fits, with more extensive coverage—yes, and a savings in costs.

Now, there is nothing complicated about the proposal. We rely upon and adopt the procedures which are followed by private carriers in their contracts with the Civil Service Commission for our Federal employees.

The CHAIRMAN. The time of the gentleman has again expired.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield myself 10 additional minutes.

All persons aged 65 or over would be eligible—eligible on a uniform basis—for insurance and protection equivalent to the Government-wide indemnity benefit plan of the Federal Government. Their participation would be voluntary. There would be no means test. Enrollment would be during an initial enrollment period followed by periodic enrollment periods. This is the same system we use for our own Federal employees. For those under social security or the railroad retirement, enrollment would be exercised by the assignment of a premium contribution or a checkoff against the individual's current social security benefits. Those not under social security, would execute an application accompanying it with their initial premium contribution. State agencies would be granted an option to purchase the insurance for their old-age assistance and medical assistance for the aged recipients at a group rate. Premium contributions by the individual would be based on the cash benefits which they receive under the OASDI.

Premium contributions by individuals would be based upon the cash benefits which they receive under the OASI system. The premium would be 10 percent of the minimum social security benefit and 5 percent of the balance. Those receiving the lowest social security benefits would pay the least. The average premium contribution on the basis of the bills' benefit levels would be \$6.50 per month per person.

Persons not under social security would pay a premium equivalent to the maximum contribution of an individual under social security. The remainder of the cost of the insurance would be paid by the Federal Government out of general revenues.

Benefits would be paid out of a National Health Insurance Fund. The fund would receive as deposits the contributions of individuals, assignments from the social security system and railroad retirement board on behalf of individuals who have authorized a checkoff of their cash benefits, State contributions for OAA and MAA recipients, and annual appropriations from the Federal Treasury.

The Secretary of the Treasury would administer the fund.

The insurance program would be administered by the Department of Health, Education, and Welfare, which would be charged with general administration, recordkeeping, and so forth, but would not process the claims or bills of hospitals, physicians, and the like.

The Surgeon General would contract

with private agencies Blue Cross-Blue Shield, for example, which would process and pay the claims of those furnishing services and would then be reimbursed from the National Health Insurance Fund.

The Surgeon General would contract with private agencies and insurers just like we do in the Federal health insurance plan, which would then pay the claims of those furnishing the services, such as doctors and hospitals, and would be then reimbursed from the National Insurance Fund.

The chairman has suggested and others have suggested that this is a more costly method. It is not a more costly method. I hope we can show you in terms of cost to the Government—in terms of cost to the taxpayers—that we offer a plan here which is less costly to the taxpayers than that of the committee bill.

Let me say this: The estimates of the cost of this program have been made by the chief actuary of the Department of Health, Education, and Welfare, who has also made the estimates of the cost of the committee bill. On February 9, shortly after I introduced the bill embodying the provisions of this alternative plan, the actuary, in whom I have a great deal of confidence, estimated that this program would cost on an average of \$20 a month for each participant. That is the premium you would have to charge if the program were fully financed by premiums.

On February 16, a week later, however, the same actuary gave us an estimate of \$16. Now I am told that if the same assumptions were used that have been used in estimating the cost of the committee bill, the estimate might be back up to \$20 per month. There has been a new estimate of the cost of our program on the same actuarial basis, using the same conservative assumptions; and the estimate now comes to a benefit level cost of approximately \$20 per month per individual. That is the benefit side.

But where do we have the savings? Where is the difference in the cost between the two plans? In the first place, the program I advocate is voluntary, whereas the hospitalization program under the committee bill is compulsory.

The voluntary aspect of the program automatically reduces the cost; it reduces the cost of the voluntary program of supplemental benefits in the committee. I believe, the estimate of utilization under that program is something like 85 or 90 percent.

Mr. MILLS. Eighty to ninety-five percent.

Mr. BYRNES of Wisconsin. Eighty to ninety-five percent; that is the estimate that is used for the voluntary system in the committee bill. Of course, as you reduce the number of people participating, the basic cost is reduced; and, using the same fundamental estimate of utilization for our overall package, the general revenue cost is \$2 billion a year. The premium cost is \$1 billion. So you come to a benefit cost of \$3 billion and you come to a taxpayer cost of \$2 billion

under the comprehensive bill that I have proposed.

Let us look at the cost of the committee bill. We have to look at both packages; not just the hospital package, and not just the doctors' service package. What is the combined cost in dollars to the taxpayers. As far as cost to the taxpayers is concerned it is \$2,860 million under the present estimate of which \$835 million is from the general fund, and \$1.25 billion is from the payroll tax. They tell you how sufficient it is to have a proposal that would finance hospital benefits out of the general fund, which is programed separately and is not tied in with social security.

Let me call your attention to the fact that the hospital program, largely financed by the payroll tax, still uses an appropriation from the general fund to finance a part of the hospital program. For the first full year of operation the estimate—and the tables appear in the committee report—shows that the cost to the general fund will be \$275 million in that year for the hospitalization program.

This in effect is the manner in which the hospitalization program is financed: For those over 65 today who are drawing a social security cash benefit, their hospitalization will be financed from the payroll tax; for those over 65 who are not eligible for social security benefits, their hospitalization will be financed from the general fund.

Now, Mr. Chairman, I ask you, if the medical care program is separate from the social security system and the payroll tax, how can you draw a distinction between those who have already retired who are not drawing a social security benefit and those who are?

Mr. Chairman, you cannot logically draw such a distinction. There is none. Those presently retired have had no connection with the tax for hospitalization which is imposed under the committee bill. This is true whether they are drawing social security benefits or not. Why then should their hospital benefits be financed on a different basis?

The CHAIRMAN. The time of the gentleman from Wisconsin has again expired.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield myself 5 additional minutes.

But where do you end up? Where do you end up as you add up the cost of the committee bill?

The cost of the hospital and the voluntary supplemental services under the committee bill in the first full year of operation is \$2.8 billion of taxpayers' funds, either payroll taxpayers or general taxpayers. Under our substitute, the total cost as far as the general taxpayer is concerned in the first full year of operation is \$2 billion. There is where the difference in cost is, Mr. Chairman, and it is there in black and white. We do not have to do any searching for it. A large part of the savings results from the fact that the substitute program is on a voluntary basis. Hospitalization under the committee bill is compulsory. In addition the substitute bill is contributory. I believe experts in the field will

agree that the contributory factor is a substantial element in reducing abuses; namely, excessive utilization of benefits.

Then, finally, Mr. Chairman, I would also point out that the bill I propose provides for a special recoupment of the subsidy from those who are well able to pay the full cost of their subsidy. We do it by way of a special tax applied to those people with an individual income of over \$5,000 a year and we recoup \$10 for each \$100 of income in excess of \$5,000 up to a recoupment of \$100 which represents the amount of subsidy contained in the policy that they purchase from the Government. Therefore, no one can contend that we are providing a benefit for the rich and a benefit to those who can well afford to take care of themselves.

But may I point this out, Mr. Chairman? My objection to the committee bill is not on the basis of the cost. My objection is to the means used to finance the benefits; namely, the payroll tax.

The committee bill would finance the major cost of medical care for the aged—the hospitalization program—through the social security system. One hundred percent of that cost will be paid for by today's workers—and tomorrow's workers—for 19 million persons over age 65. These 19 million persons will pay nothing. This amounts to approximately two-thirds of the total cost of the combined package of benefits.

The administration bill would finance the balance of its package—the medical services—one-half out of general revenues and one-half by premium contributions.

In summary, the committee bill finances two-thirds of the cost through the social security system, one-sixth of the cost through general revenues, and one-sixth of the cost by premium contributions.

The substitute bill would finance two-thirds of the cost through the general revenues and one-third of the cost by premium contributions.

The committee bill would finance the major cost of medical care for the aged and the hospitalization program through the social security system, and you cannot get away from it.

The chairman of the Committee on Ways and Means has suggested that because they are stated separately that there is a practical separation. Mr. Chairman, we did the same thing in establishing the disability program a number of years ago. We know what that tax is producing in revenue. We know how much it is short, if it is short.

We just recently in the committee discussed the whole issue of what we had to do in order to bring the tax up and balance out the disability part of the system, because we keep separate records.

Mr. MILLS. Mr. Chairman, will my friend yield to me at that point?

Mr. BYRNES of Wisconsin. Yes, I yield to the gentleman from Arkansas.

Mr. MILLS. Permit me to ask the gentleman if the statement I made was not correct, that the OASI and the DI taxes are levied together, and then an allocation is made between the OASI and the DI trust funds?

We have done exactly that very thing in this bill before the committee today with regard to those two programs, but it could not happen with respect to the hospital insurance tax.

Mr. BYRNES of Wisconsin. It is bound to, when you are assessing it against the same taxpayer, on the same basis; you are combining the taxes. Look at the tables in your committee report. You have done that.

Mr. MILLS. No, we did not combine it. There is no combined table in the report except in the minority views. It is in an entirely separate section of the Internal Revenue Code, and there cannot be a transfer to one from the other. The proceeds of the hospital insurance trust fund have to be kept legally separate. The gentleman knows we did not do that with respect to the disability program. In the latter case, we provide for separation of funds, not a separation of tax.

Mr. BYRNES of Wisconsin. I know the gentleman has gone to great lengths to make it appear that there has been a separation; but wait and see, when this bill is enacted the tax that will be applied against the employees and the employers will be the total tax, a tax assessed to take care of the hospitalization and the tax that is required, the percentage rate that is required, to take care of the old-age survivors and disability insurance system. There is not going to be any separation, in point of fact, at the taxpayer level or even in the Treasury. When it comes to keeping records, sure, you will know what each fund has collected, but we know that today on the disability side.

Mr. MILLS. I think the gentleman is talking about one point with respect to separation, and I am talking about another point. We do not go to the extent, and the gentleman is right, as I said a few minutes ago to him, of requiring the taxpayer to make two separate computations. I am talking about separation of the tax and the trust fund from the point of view of the preservation of the OASDI Trust Funds from any inroads or intrusion by the Hospital Insurance Trust Fund. The gentleman must admit that. Permit me to again refer to page 48 of the report which reads:

The hospital insurance program would be completely separate from the old-age, survivors, and disability insurance system in several ways, although the earnings base would be the same under both programs. First, the schedules of tax rates for old-age, survivors, and disability insurance and for hospital insurance are in separate subsections of the Internal Revenue Code (unlike the situation for old-age and survivors insurance as compared with disability insurance, where, there is a single tax rate for both programs, but an allocation thereof into two portions). Second, the hospital insurance program has a separate trust fund (as is also the case for old-age and survivors insurance and for disability insurance) and, in addition, has a separate Board of Trustees from that of the old-age, survivors, and disability insurance system. Third, the bill provides that income tax withholding statements (forms W-2) shall show the proportion of the total contribution for old-age, survivors, and disability insurance and for

hospital insurance that is with respect to the latter. Fourth, the hospital insurance program would cover railroad employees directly in the same manner as other covered workers, and their contributions would go directly into the hospital insurance trust fund and their benefit payments would be paid directly from this trust fund (rather than directly or indirectly through the railroad retirement system), whereas these employees are not covered by old-age, survivors, and disability insurance (except indirectly through the financial interchange provisions). Fifth, the financing basis for the hospital insurance system would be determined under a different approach than that used for the old-age, survivors, and disability insurance system, reflecting the different natures of the two programs (by assuming rising earnings levels and rising hospitalization costs in future years instead of level-earnings assumptions and by making the estimates for a 25-year period rather than a 75-year one).

Mr. BYRNES of Wisconsin. You have made provision so as to prevent borrowing from the other funds. I recognize that. But the same thing exists today with respect to the disability insurance fund, they have to come back for an increase in the tax rate if they run short.

Mr. MILLS. What do we do? In the case of the disability fund, we allocate from the total tax of OASDI an amount in addition to that. That could not happen under this bill for the hospital insurance trust fund.

Mr. BYRNES of Wisconsin. I understand you are not doing it, but when you come down to the nub of the question you are tying it into the social security taxpayer. You have the same taxpayer, you have the same rate base.

Mr. MILLS. What about the railroad employees? They are not under social security, yet they are taxed, and the employers taxed for this purpose.

Mr. BYRNES of Wisconsin. That is of little consequence as far as I am concerned, and as far as practicability is concerned, whether it runs through the railroad retirement system, then gets into the Treasury, or whether it goes directly from the railroad and the employee into that fund. The difference, Mr. Chairman, as far as I am concerned, and I think any practical person who looks at it must admit it, the effect is you are tying this into the social security system. You can put in gimmicks that look like you are separating it, you can do all of the rationalization you want to, but you still have them both tied together.

The mere fact, Mr. Chairman, that you are going to deny hospitalization benefits to those who become 65 after 1968 unless they have paid social security taxes shows how you tie the two programs together. You cannot qualify for health benefits without also qualifying for the cash benefits under social security. If you are eligible for cash benefits you are eligible for hospital benefits.

My primary concern—and I am certain the chairman of our committee shares that concern—is to protect cash benefits under social security. That is the foremost and basic need of the elderly. Cash benefits will be secure only so long as we do not overburden the pay-

roll tax system which is used to finance those benefits.

The payroll tax is a very regressive tax. It can be carried to the breaking point. Let me just read you from the speech which the chairman of our committee made as recently as September 28 last year. He said:

I have always maintained that at some point there is a limit to the amount of a worker's wages, or the earnings of a self-employed person, that can reasonably be expected to finance the social security system. Not only is this a gross income tax, but it adds to the cost of American goods and services and thus affects our competitive position. I do not believe that the American people will support unlimited taxation in the area of social security.

Again in December of last year, he added a note of caution. Because he so well summarizes my views of the dangers inherent in such a tax, I would like to read a paragraph from that speech:

I hasten to add, however, that the concept of a payroll tax cannot be judged adequately without reference to, what kind of payroll tax. A major point to be considered in this regard is, what effect does the tax proposed have prospectively on other sources of revenue. Specifically in regard to the aged, we must remember that the primary needs of our senior citizens are for adequate cash benefits. The amount must be sufficient to produce a dignified standard of living when added to other spendable assets characteristic of the aged. Further, the amount must be raised periodically to keep in step with decreasing purchasing power of the dollar. A payroll tax to pay for health benefits, as I have stated before, should not be added to or harnessed with one to pay for cash benefits. Health expenses are less predictable and they are rising considerably faster. Within a tight coupling, the cash benefit would, in all probability, be compromised and the danger increased of stressing health care at the expense of the root factors of food, shelter, and clothing.

If we pass the committee bill, we will be taking an unprecedented step in the field of social security. We will be tying into the social security system a service benefit. Not the payment of a specified amount of dollars at some future date, but payment for a specified service—hospitalization—regardless of what that service might cost.

That is why I am unalterably opposed to financing hospitalization through the social security system. You have been told that this is a separate tax with a separate fund, and everyone will know what the hospitalization program costs in terms of the payroll tax.

Once we embark on the program, will that make any difference?

I would like to remind you again that we followed precisely the same format when we set up disability benefits under social security. What has happened?

Today, the disability benefit and the regular cash benefit are linked together—we call it the old-age survivors and disability insurance system—OASDI.

Once we tie the hospitalization program to the payroll tax we are only kidding ourselves when we say that it can be separated from the cash benefits.

The same worker, the same employer, the same wage, all must finance both programs. Every percentage point that we levy as a tax for hospital benefits

means that much less available as a tax to finance cash benefits. That is the crux of the matter.

No one can honestly say that in levying this tax to finance hospital benefits we are not jeopardizing our ability at some future date to provide for an increase in cash benefits. And I happen to believe—and I believe our chairman shares my belief—that the most important consideration should be our ability to maintain cash benefits at a level which will preserve the purchasing power of those benefits to our aged citizens.

Mr. MILLS. Mr. Chairman, will the gentleman yield?

Mr. BYRNES of Wisconsin. I yield to the gentleman from Arkansas.

Mr. MILLS. Does my friend who sees such a threat to the OASDI program, which I do not see, see no danger at all to the general fund in his proposal?

Mr. BYRNES of Wisconsin. There is no question that we all have to cope with a most serious problem as far as the fiscal situation of our Nation is concerned, but that fiscal situation faces us whether the funds come through the general fund or payroll taxes. It is a burden we are placing on our taxpayers. The decision is apparently made that we are going to have a program for our older people that is going to be subsidized by the taxpayers of this country. That subsidy will be in the neighborhood of between \$2 and \$3 billion a year. That is the burden; that is the problem. You can raise it from the regressive payroll tax or on an ability-to-pay base. We can use the most regressive tax we have, which is what the committee bill proposes, falling on the workers and the low-income people, or you can rely on the progressive tax rates which we use for our general fund.

Mr. MILLS. I am sure the gentleman and I are in accord that these benefits will grow in cost in the future for no other reason than the growing number of our people over 65; but has the gentleman no fears at all of the growth of a program under the general funds of the Treasury compared to the growth of a program under dedicated or trust fund taxes?

Mr. BYRNES of Wisconsin. I would say to the gentleman I would have less concern where the program remains flexible than I would where a program is rigid as far as the practical opportunity of Congress to revise the benefit package or the method of financing. Under the payroll tax, an erroneous concept has been sold to the people that they have paid for their benefits, that they have bought something as a matter of right, under such a concept there is no flexibility to make changes because the people tell you, "We have bought this, and you cannot make any change except to liberalize it."

Under the alternative we propose, you can change the contributions by the individual and the benefit package to the individual at each period of enrollment. You can maintain flexibility, just as you do today with respect to the insurance program for Federal employees. We would not discontinue having a program of hospital and medical care benefits for

Federal employees, but we do have an opportunity to change either the nature of the package or the contributions or the subsidy that will be provided. I say to you as far as I am concerned, I see more protection for the future in something that has flexibility as compared to something that is rigid.

Mr. MILLS. Mr. Chairman, will the gentleman yield?

Mr. BYRNES of Wisconsin. I yield to the gentleman.

Mr. MILLS. The social security Old-Age, Survivors, and Disability System is actuarially sound and has been for the last 30 years. How many times have we had a balanced budget of the general fund of the Treasury into which the gentleman proposes to put this system? I am trying to say this, to emphasize the point I have made repeatedly—a payroll tax will tend to limit the growth of the benefit and will tend to do so to a greater extent than will be the case if that benefit cost is placed in the general fund of the Treasury.

Mr. BYRNES of Wisconsin. I just disagree with the gentleman. There should be no more reason for a limitation based on who the taxpayers happen to be or to whether you put it on a regressive tax basis or put it on a progressive tax basis. It seems to me that justice requires we put it on the basis of those most able to pay rather than on those who are least able to pay.

Mr. Chairman, I have used more time than I should. I would summarize by saying that the differences of opinion—the point of conflict in our whole discussion is with reference to the medical provisions as contained in the committee bill. I propose a voluntary system instead of a compulsory system. I propose a contributory system. I propose that it be financed not on the regressive payroll tax but that it be financed on the basis of our progressive tax system. I propose a system that is more comprehensive as far as the benefits are concerned.

Under the alternative proposal, the matter of need is recognized by a recoupment provision. We make sure that you are not just giving a gratuity to those who are well able to take care of their own medical needs.

Mr. JONES of Missouri. Mr. Chairman, will the gentleman yield?

Mr. BYRNES of Wisconsin. I yield briefly to the gentleman.

Mr. JONES of Missouri. The gentleman brought out a minute ago the benefits cost being estimated by the actuary at \$20 a month. Will the gentleman explain that a little clearer to me? I cannot get that through my head.

Mr. BYRNES of Wisconsin. That is the benefit package.

Mr. JONES of Missouri. What do you mean by the benefit package? Do you mean that is the cost of service to be rendered to the person who enters the hospital and that that will average out at the rate of \$20 a month?

Mr. BYRNES of Wisconsin. No, no. Mr. JONES of Missouri. That is what I want to find out.

Mr. BYRNES of Wisconsin. If you were to sell a particular package of in-

surance benefits, which provides for many days in the hospital and coverage of doctor bills, drugs, and the like, you would have to charge a premium of \$16 to \$20 a month. That is what we are talking about—the premium cost.

Mr. JONES of Missouri. But you are not going to collect that much under the additional money that is going to be raised by the increases in payroll taxes; are you?

Mr. BYRNES of Wisconsin. The gentleman is talking about the provisions in the committee bill. I am talking about my substitute. There is no payroll tax involved in the substitute. Now suppose an individual pays a premium, an average premium of \$6.50 a month. The balance is subsidized out of the general revenues. On this basis of 80 to 90 percent of utilization or participation by the group over 65 years of age and the cost would average out about \$2 billion of Government subsidy and about \$1 billion of premium cost to the group.

Mr. JONES of Missouri. In other words, am I to understand, and let me get this straight—am I to understand you are saying that a premium of \$20 a month will provide hospitalization, drugs, and doctor bills?

Mr. BYRNES of Wisconsin. Yes, sir.

Mr. JONES of Missouri. I thank the gentleman.

Mr. BYRNES of Wisconsin. The same program that is provided for our Federal employees.

I would hope that this committee in this House would exercise its good judgment in saying:

First. Let us do nothing that would jeopardize in any degree our ability to maintain the cash benefit program which is the underlying basis of protection that our older people rely on.

Second. Let us do something for our aged people and make sure that there are none of our older people who want for medical care and that they have assurance they will have their medical needs taken care of.

If we are to do those two things, then we will vote for the substitute as opposed to the bill reported by the committee.

Mr. MILLS. Mr. Chairman, I yield 20 minutes to the distinguished gentleman from California [Mr. KING].

(Mr. KING of California asked and was given permission to revise and extend his remarks.)

Mr. MILLS. Mr. Chairman, will the gentleman yield to me?

Mr. KING of California. I am pleased to yield.

Mr. MILLS. I wanted to take this occasion to pay deserved tribute to the gentleman from California.

It has been my privilege to sit next to the gentleman for several years on the Committee on Ways and means. I know of no one for whom I have a deeper affection or any greater respect and higher regard than the gentleman from California. Throughout the years we have served on the committee together—while I have been the chairman and he has been the ranking Democrat—it has been a source of great satisfaction to me to know that at all times I have had his full and complete cooperation. I want-

ed the membership of the House and the people of the country to know that he has made a major contribution in the development of the legislation which is presently before the House. In fact, many of the provisions he introduced in his bill, H.R. 1, in addition to the provision which is in the bill on the basic plan for hospitalization insurance with which he is most closely identified, are contained in the pending bill.

The gentleman has made many contributions in many fields, but I doubt if he has made any greater contribution ever than in the development of this bill, H.R. 6675.

I want it to be known that I had such a feeling about the gentleman's contribution and the part that he played in this matter over the years that, after the committee directed me to introduce the committee bill—that is why it is in my name, because I happen to be chairman of the committee and the committee directed me to do so—I asked the gentleman from California to introduce an identical bill accompanying this one—H.R. 6676—because certainly he is entitled to the commendation of the American people as much as any man here today for much of what is in this bill.

I take my hat off to him again. I have done so on many occasions in the past.

In spite of all the many admirable features of the gentleman, I must say his intense loyalty to his purpose, to his people, to his country, and particularly to his colleagues here impresses me as much as any other of his many fine attributes.

Mr. Chairman, will the gentleman yield further?

Mr. KING of California. I am pleased to yield.

Mr. MILLS. My distinguished friend from Wisconsin was very kind to yield and I appreciated the fact that he did, though I took too much of his time. He and I so often find ourselves in agreement that it is difficult for me to find us in disagreement factually about two matters in this bill. One has to do with the question of separation of hospital insurance from the present social security insurance system itself. We went into the matter in the report on pages 33 and 48, as my friend from California knows, and pointed out 5 distinct differences in the operation of the OASDI system and this new program of hospital insurance.

My friend used an argument to say that they were one and the same because the hospital insurance matter included a lot of people not under social security.

I think he misled me as to what he meant, or maybe he mispoke himself, because I did not quite understand that as the reason. The fact that more people are in the health insurance program than the social security program I do not believe is a justifiable argument for saying the two are identical.

Mr. BYRNES of Wisconsin. Mr. Chairman, will the gentleman from California yield to me?

Mr. KING of California. I yield to the gentleman.

Mr. BYRNES of Wisconsin. I am sorry I did not make myself clear.

Mr. MILLS. You did to everyone but me, I am sure.

Mr. BYRNES of Wisconsin. What I was pointing out to the chairman was that we have today a group of people who are over 65 who are not under social security or railroad retirement—the so-called uninsured. Under the committee bill they will all be made eligible and are all automatically eligible except—for a reason that I cannot quite understand—except for Federal employees who retired after July 1, 1960 the effective date of the Federal Employee Health Benefits Act of 1959. They are the only people put in a separate category, and you say, "No, you cannot qualify for hospitalization, but everybody else over 65 is going to be eligible for hospitalization."

Mr. MILLS. But that is not the case.

Mr. BYRNES of Wisconsin. But the cost of the benefits for those over age 65 is not all paid out of the same source of revenue. The bill makes a distinction in how you are going to pay for some of these people. For those who are drawing social security benefits, the benefits are paid out of funds derived from the payroll tax levied under the hospitalization program, but for those who are not drawing a social security benefit, the benefits are paid out of the general fund. My point is, if the hospitalization program is separated from the social security system—and none of these people over age 65 will have paid 1 cent of the tax imposed for the hospitalization phase of this program—then why should their benefits be paid from two different sources of revenue? Why should any of the benefits be paid out of general revenues if it is not tied in with the social security system?

Mr. MILLS. The gentleman put his finger on one of the very things that points up the difference between the hospital insurance trust fund and the old-age, survivors, and disability insurance trust fund. The fact that we take more people into the hospital program than are eligible under social security should be convincing to the gentleman that there is some distinction.

Mr. BYRNES of Wisconsin. Why do you pay the benefits from a different source?

Mr. MILLS. Because they come from different areas. Some come from railroad retirement, some come from social security, and some—the uninsured—come without any coverage under either program. My friend knows we have taken in far more people than are just eligible for social security benefits.

Now, will my friend from California yield further?

Mr. KING of California. I am pleased to yield to the gentleman.

Mr. MILLS. The other point of disagreement is in regard to cost estimates and assumptions. The gentleman said that his program, so far as the general fund and the Treasury are concerned, would cost \$2 billion in the first year. I thought I understood him to say that it

represented a per capita cost of \$20 per month for a person who went into the system. Was that the figure the gentleman used—\$240 a year?

Mr. BYRNES of Wisconsin. That would be the highest cost estimate.

Mr. MILLS. That is right.

Mr. BYRNES of Wisconsin. There is an intermediate cost estimate of \$16 per month and a low cost; \$20 is the high cost.

Mr. MILLS. We used the high-cost estimate for the committee bill, and I wanted to ask the gentleman about that. The gentleman would still let them pay \$6 per month out of their pocket for the health benefits?

Mr. BYRNES of Wisconsin. An average payment would be \$6.50.

Mr. MILLS. That would be the average payment?

Mr. BYRNES of Wisconsin. Yes.

Mr. MILLS. That would produce something like \$1.22 billion of revenue per year, as I estimate it.

Mr. BYRNES of Wisconsin. That is at 100 percent. The gentleman is using 100 percent.

Mr. MILLS. No. That is at 90 percent participation. It is 90 percent, because 90 percent of the total population aged 65 or over adds up to 17 million people, and I am just multiplying here \$240 by 17 million, and I come up with a total cost of \$4.08 billion in the first full year of operation.

If we take from that the amount that the persons themselves will contribute, Mr. Myers tells us in his memorandum to you and to the committee that was sent us while we were in executive session, using the high-cost estimates now, however, that your program providing benefits and taking care of administrative expenses, would cost the general funds of the Treasury in its first year of operation \$2.86 billion, not the \$2 billion the gentleman comes up with when he uses intermediate cost estimates.

Mr. BYRNES of Wisconsin. Why do we not just quote from the letter of February 26, taking the third paragraph of the letter, where Mr. Myers estimates the cost of my program?

Mr. MILLS. But what I wanted to point out is that maybe some of the basis for this conclusion of the gentleman from Wisconsin that I just could not anticipate or understand or believe, that you can do more under one program than you do under another program, but that the program that does the most is going to cost the least. Maybe that results from the fact that in one instance a high-cost estimate is used, while in the other instance an intermediate-cost estimate is used, and in the other a low-cost estimate is used. If you do that, you can get a program providing a lot more benefits that appears to cost less, but the facts are that they are going to cost whatever they cost, and we are going to have to make it available from some source.

I am somewhat amazed by the inferences from the separate views of the minority in the committee report that the hospital benefits program is not ade-

quately financed by the bill. The minority states that there are safety factors in the cash benefits system, but that this is not the case as to the hospital benefits program. This is strange because the minority members were at the very committee meetings where, time after time, I requested that additional safety factors be placed in the assumptions.

The current assumptions as to hospital utilization, both in the early years and over the long run, reflect these added safety factors. The actuarial assumption that the earnings base would be kept up to date was replaced with an assumption that the base will not rise after 1971. This is very conservative, and if the base is subsequently raised by Congress above this amount, the tax rate can be reduced under this conservative assumption. As to the future increases in hospital costs relative to wages, the committee assumption is more conservative than that presented by the actuaries representing the insurance industry.

To put this all into perspective, I would like to insert into the RECORD at this point a memorandum from Robert J. Myers, chief actuary of the social security system, whose competency and integrity is unquestioned by Members on both sides of the aisle, commenting on the safety factors in the bill. He states, in summary:

The actuarial cost estimates for the hospital insurance system that would be established by H.R. 6675 are based on assumptions that are not only reasonable, but also conservative (in the sense that they tend to be either "high-cost" assumptions or else assumptions that have built-in safety margin in regard to future changes in economic conditions).

The memorandum is as follows:

APRIL 1, 1965.

From: Robert J. Myers.

Subject: Principal aspects of actuarial assumptions underlying cost estimates for hospital insurance benefits of H.R. 6675.

The actuarial cost estimates for the Hospital Insurance system that would be established by H.R. 6675 are based on assumptions that are not only reasonable, but also conservative (in the sense that they tend to be either "high-cost" assumptions or else assumptions that have a built-in safety margin in regard to future changes in economic conditions). This may be indicated by considering the four most important cost factors involved in these estimates—namely, hospital utilization rates, the current level of reimbursable average daily hospitalization costs, future trend of hospitalization costs, and future changes in the maximum taxable earnings base for the program. Each of these factors will be considered in turn.

A. Hospital utilization rates: The rates used in the current cost estimates are 20 percent higher than those used in the cost estimates for the administration proposal of 1965 in the initial years of operation, and 10 percent higher in the long run. The rates used previously were reasonable and were developed from extensive analysis of survey data, with appropriate adjustments being made for the effect of "insurance benefits" being available to the entire eligible population and for deceased persons who were omitted from the survey.

B. Current level of reimbursable average daily hospitalization costs: The 1966 figure used as the base point has been projected from the most recently available actual data

(for 1963) by assuming that hospitalization costs would increase at the same average rate as in the past decade, even though there is clear evidence that the rate of increase has slackened off some. The downward adjustments that have been made in the basic data obtained from the American Hospital Association¹ have been analyzed further on the basis of a number of sources of information, and I believe that the aggregate effect is that the reduction made is conservative.

As compared with the procedure for previous estimates for Hospital Insurance proposals, the current method in regard to this factor is more conservative. This is the case because it begins with the estimated figure that will actually occur in the first year of operation, rather than with the lower figure based on an earlier year; namely, that for the earnings assumptions for estimating the contribution income (1963).

C. Future trend of hospitalization costs: It is assumed that hospitalization costs will increase more rapidly than the general level of wages in the first 5 years—namely, by the same average differential that has prevailed on the average in 1954–63, even though there has been clear evidence of a downward trend (i.e., the rate of increase of hospitalization costs becoming more nearly the same as the rate of increase of the general wage level). After the first 5 years of operation, the differential of the increase in hospitalization costs over the increase in wages is assumed to lessen, and following 1975, hospitalization costs and wages are assumed to rise at the same rate. This is a much more conservative assumption than was used in earlier cost estimates for administration proposals—namely, that over the long run, from the inception of the program, hospitalization costs would increase at exactly the same rate as wages. Also, it is somewhat more conservative than the corresponding assumptions recommended by the Advisory Council on Social Security Financing, and slightly more conservative than the assumptions that the insurance business made in its estimates.

D. Future changes in maximum taxable earnings base for program: The conservative assumption is made that, despite the assumption that the general wage level will rise by 3 percent annually during the 25-year period considered in the cost estimates, the maximum taxable earnings base will not be changed from the pertinent provisions in the bill (namely, an earnings base of \$5,600 in 1966–70 and of \$6,600 thereafter). In essence, this is a built-in safety factor in the hospital insurance program, because it seems most likely that if wages continue to rise steadily after 1971, then at some time thereafter the earnings base will be adjusted upward. Under such circumstances, the contribution schedule developed could, if all other cost assumptions are exactly realized, be reduced.

In all cost estimates made previously, it was assumed that the earnings base would be increased from time to time in a proportionate manner with changes in the general earnings level. If such changes did not occur, then the cost of the program would be higher than in the estimate.

Finally, it may be mentioned that there is still another conservative element in the cost estimates that is present both in regard to H.R. 6675 and also has always been present—namely, that the proposals are to be financed by a certain amount of advance funding,

rather than being on a completely (or nearly) pay-as-you-go basis. Thus, for example, under H.R. 6675, in the first year of operation the estimated contributions are 61 percent in excess of benefit payments. In the next 3 years of operation, this differential averages about 15 percent each year.

ROBERT J. MYERS.

I would think that the gentleman would better proceed in a more conservative fashion on the basis of a high-cost estimate for his program, just as we have used in the committee bill. If he does, the first-year cost will not be \$2 billion out of general revenues, but rather a higher figure—by \$860 million in the first full year of operation.

Mr. BYRNES of Wisconsin. Mr. Chairman, I hate to use so much of the time of the gentleman from California, but I do think the gentleman is perfectly right, that we should get this whole cost matter thrashed out so everybody understands it.

Mr. MILLS. That is right.

Mr. BYRNES of Wisconsin. If the gentleman will allow for half a minute, I should like to quote the last estimate made by the actuary, in a letter dated February 26. I believe this is the last estimate.

Mr. MILLS. April 5 is the last I have. It refers to the one of February 26.

Mr. BYRNES of Wisconsin. Mr. Myers is talking about the cost estimates for the Byrnes bill—revised. This is the third paragraph in the memorandum which is at the heart of it. I say:

If there were 100 percent participation, in Federal cost for the first full year of operation (which could be assumed to be fiscal year 1966 to 1967) it is estimated at \$2.4 billion, while the participants themselves would contribute about \$1,250 million. With 80 percent participation, the Government cost would be \$1.9 billion while the participants would pay \$1 billion; and with 50 percent participation the corresponding figure would be \$1.2 billion and \$0.6 billion, respectively.

I point out in my remarks that it is not anticipated that you would have 100 percent participation under a voluntary program. We have people who already have a system that is adequate for their needs and would not participate.

All I can do, Mr. Chairman, is cite to you the language of the actuary on whom you rely and, frankly, on whom we rely. At least we do not have a difference of opinion of two different actuaries.

Mr. MILLS. We have the same actuary, and we all have great confidence in him. I want to suggest that when we get back in the House, the gentleman, at this particular point in the Record, insert the memorandums from the actuary dated February 9 and 26. And let me at the same time include what he has supplied me in the form of a memorandum dated April 5, 1965, in which he says that if we use high-cost estimates—compared to the intermediate-cost estimate used in the memorandum of February 26—for your plan on a 90-percent assumption of enrollment, and high-cost estimates for the committee plan, that we bring the costs of the two together on a comparable basis.

Mr. BYRNES of Wisconsin. I would certainly like to see the revised estimate. I thought I was receiving the material relating not only to the cost of my bill but the cost of the committee program. I did not know that there was an undercover change in the estimates. I relied on the first two estimates made by the actuary.

Mr. MILLS. This is the same actuary that the gentleman has great confidence in. If the gentleman will let me explain the April 5 memorandum I have, it does nothing more than refer to the February 6 and 26 memorandums and explains those memorandums with relationship to a high-cost actuarial estimate as we asked for toward the end on the committee bill. I will show this to the gentleman, and I will also show him a memorandum prepared today that uses the same \$6.50 average monthly premium payable by the participants that the gentleman cites, instead of the average premium of \$6 that is used in the April 5 memorandum. I include at this point in the Record the memorandums of Mr. Myers dated February 9, February 26, April 5, and April 7:

MEMORANDUM OF FEBRUARY 9, 1965

From: Robert J. Myers.

Subject: Cost estimate for the Byrnes bill.

This memorandum will present a cost estimate for the first full year of operation of the Byrnes bill, H.R. 4351, which would establish a program of voluntary comprehensive health insurance for all persons aged 65 or over. In making a cost estimate for this proposal, it is impossible to predict with any exactitude what proportion of the eligible persons will actually elect to participate. Three different participation assumptions are made—namely, 100 percent, 80 percent, and 50 percent. Although it is recognized that complete 100 percent participation will never be possible because of the parallel existence of the plan for persons under the civil service retirement program and because of low-income persons not on old-age assistance but who could possibly qualify for medical assistance for the aged under an adequate State plan not electing to participate.

If there were 100-percent participation, the Federal cost for the first full year of operation is estimated at \$3.3 billion, while the participants themselves would contribute about \$1¼ billion. With 80 percent participation, the Government cost would be \$2.6 billion, while the participants would pay \$1 billion, and with 50 percent participation the corresponding figures would be \$1.7 billion and \$0.6 billion, respectively.

It should be mentioned that dollar costs in future years will be increasingly higher than those for the first full year of operation. As to the participant contributions, this will be the case because of the larger number of eligible persons and because of higher benefit amounts (since those currently coming on the roll tend to have somewhat larger benefits than those who retired in previous years). The Government cost would increase at a more rapid rate than the cost for participants because of the anticipated more rapid rate of increase of medical costs than will be true for wages, which in turn will increase more rapidly than benefit amounts.

One of the cost aspects of the proposal should be mentioned—namely, the increased cost to the OASDI system as a result of the liberalization of the earnings test. In fact, an amount of benefit equal to the monthly health contribution is made exempt from the earnings test for all persons aged 65 and over (regardless of whether or not retired).

¹ The adjustments have been made to allow for the inclusion of non-reimbursable items (such as the cost of operating restaurants and gift shops, the cost of outpatient clinics, etc.), the lower average daily cost for persons aged 65 and over (because of their longer average stays), and the adjustment to allow for exclusion of all physicians' services.

The estimated level-cost of this change in the earnings test is 0.07 percent of taxable payroll.

ROBERT J. MYERS.

MEMORANDUM OF FEBRUARY 26, 1965

From: Robert J. Myers.

Subject: Cost estimate for the Byrnes bill.

This memorandum will present a cost estimate for the first full year of operation of the Byrnes bill, H.R. 4351, which would establish a program of voluntary comprehensive health insurance for all persons aged 65 or over, effective January 1, 1966. In making a cost estimate for this proposal, it is impossible to predict with any exactitude what proportion of the eligible persons will actually elect to participate. Three different participation assumptions are made; namely, 100 percent, 80 percent, and 50 percent. Although it is recognized that complete 100-percent participation will never be possible because of the parallel existence of the plan for persons under the civil service retirement program and because of low-income persons not on old-age assistance but who could possibly qualify for medical assistance for the aged under an adequate State plan not electing to participate.

The current cost estimate uses a figure of \$16 per capita for benefits and administrative expenses (or 79 percent above the H.R. 1 cost of about \$9). It may be noted the insurance industry uses a figure of \$19.40 for the Byrnes bill—\$18.50 for benefit costs, plus 5 percent for administrative expenses (or 55 percent above its estimate of \$12.50 for H.R. 1).

If there were 100-percent participation, the Federal cost for the first full year of operation (which could be assumed to be fiscal year 1966-67) is estimated at \$2.4 billion, while the participants themselves would contribute about \$1¼ billion. With 80-percent participation, the Government cost would be \$1.9 billion, while the participants would pay \$1 billion, and with 50-percent participation the corresponding figures would be \$1.2 and \$0.6 billion, respectively.

It should be mentioned that dollar costs in future years will be increasingly higher than those for the first full year of operation. As to the participant contributions, this will be the case because of the larger number of eligible persons and because of higher benefit amounts (since those currently coming on the roll tend to have somewhat larger benefits than those who retired in previous years). The Government cost would increase at a more rapid rate than the cost for participants because of the anticipated more rapid rate of increase of medical costs than will be true for wages, which in turn will increase more rapidly than benefit amounts.

One of the cost aspects of the proposal should be mentioned; namely, the increased cost to the OASDI system as a result of the liberalization of the earnings test. In fact, an amount of benefit equal to the monthly health contribution is made exempt from the earnings test for all persons aged 65 and over (regardless of whether or not retired). The estimated level cost of this change in the earnings test is 0.07 percent of taxable payroll.

ROBERT J. MYERS.

MEMORANDUM OF APRIL 5, 1965

From: Robert J. Myers.

Subject: Cost estimate for the Byrnes bill, H.R. 7057.

This memorandum will present a cost estimate for the first full year of operation of the Byrnes bill, H.R. 7057, which would establish a program of voluntary comprehensive health insurance for all persons aged 65 or over, as well as make revisions in the OASDI program. I have presented cost estimates for the almost identical proposal that Mr. BYRNES of Wisconsin made previously, as contained in H.R. 4351, for which I gave cost

estimates in my memos of February 6 and 26. I am assuming a participation rate of 90 percent, since this is what Mr. BYRNES of Wisconsin hypothesizes in his explanation of the bill in the CONGRESSIONAL RECORD for April 1, pages 6507-6509.

Under this participation assumption, there would be about 17 million persons who would participate in the program in the first full year of operation. The average contribution from the participants would be about \$6 per month (higher than the figure of \$5.50 used previously, because of the increase in the OASDI cash benefits resulting from title III of the bill). Accordingly, the annual rate of contributions from the participants would be \$1.22 billion.

According to an intermediate-cost estimate, the monthly per capita cost of the benefits and administrative expenses would be \$16 (as per my memorandum of February 26), so that the total annual cost would be \$3.26 billion, thus leaving \$2.04 billion as the cost from general revenues. On the other hand, if the per capita cost assumptions are high-cost ones (as per my memorandum of February 6)—thus paralleling the cost assumptions used for H.R. 6675—the annual cost for benefits and administrative expenses would be \$4.08 billion, thus making the cost from general revenues be \$2.86 billion. This figure may be contrasted with the estimate of \$2 billion given in Mr. BYRNES' statement, which apparently is thus based on intermediate-cost assumptions that are not consistent with those in the cost estimates underlying H.R. 6675.

ROBERT J. MYERS.

MEMORANDUM OF APRIL 7, 1965

From: Robert J. Myers.

Subject: Cost estimate for the Byrnes bill, H.R. 7057, on basis of average participant payment of \$6.50 per month.

This memorandum will present a cost estimate for the first full year of operation of the Byrnes bill, H.R. 7057, which would establish a program of voluntary comprehensive health insurance for all persons aged 65 or over, as well as make revisions in the OASDI program, on the basis that the average monthly premium payments from participants will be \$6.50. I have presented cost estimates for the almost identical proposal that Mr. BYRNES made previously as contained in H.R. 4351, for which I gave cost estimates in my memos of February 6 and 26 and in my memo of April 5, which was based on an average participant payment of \$6. I am assuming a participation rate of 90 percent, since this is what Mr. BYRNES hypothesizes in his explanation of the bill in the CONGRESSIONAL RECORD for April 1, pages 6507-6509.

Under this participation assumption, there would be about 17 million persons who would participate in the program in the first full year of operation. Accordingly, the annual rate of contributions from the participants would be \$1.33 billion.

According to an intermediate-cost estimate, the monthly per capita cost of the benefits and administrative expenses would be \$16 (as per my memorandum of February 26), so that the total annual cost would be \$3.26 billion, thus leaving \$1.93 billion as the cost from general revenues. On the other hand, if the per capita cost assumptions are high-cost ones (as per my memorandum of February 6)—thus paralleling the cost assumptions used for H.R. 6675—the annual cost for benefits and administrative expenses would be \$4.08 billion, thus making the cost from general revenues be \$2.75 billion. This figure may be contrasted with the estimate of \$2 billion given in Mr. BYRNES' statement, which apparently is thus based on intermediate-cost assumptions that are not consistent with those in the cost estimates underlying H.R. 6675.

ROBERT J. MYERS.

Mr. MILLS. Mr. Chairman, how much time has the gentleman from California consumed?

The CHAIRMAN. The gentleman from California has consumed 14 minutes.

Mr. MILLS. Theoretically he has, but the RECORD will show differently.

Mr. Chairman, I yield to the gentleman 14 additional minutes.

Mr. KING of California. Mr. Chairman, I hesitated to join in this discussion. I thought that I had a simple answer. I am not often asked for my opinion, but in this case I could say that a voluntary program doing less for fewer people would certainly cost less and I do not think you have to be a mathematician to arrive at that conclusion.

Mr. Chairman, the legislation which this House will pass tomorrow as debate ends—and in my opinion it will pass overwhelmingly—is the culmination of many years of public-spirited effort by many sincere and dedicated men, some of whom are here today but others of whom have passed from this scene. One thing, I believe, all of these people have had in common is a sincere and deep-seated desire to help their fellowman and a compassion for those who by fate or circumstance beyond their control face problems with which the average frugal aged citizen in this automated age are unable to cope.

One thing which is understood by openminded and farsighted legislators, and, indeed, all fairminded men of the times, is that society and our economy do not ever stand still. If Government is to keep pace with the demands of the times, then Government must develop those programs and policies which are necessary to meet the emerging needs of our citizens. So it is with this legislation today. Here we have a monument to what ultimately can be done in the face of very great inertia on the part of many and despite extended and, at times, vociferous overt opposition from those forces which always oppose change.

Those who have already spoken, including our brilliant chairman of the Committee on Ways and Means, our colleague WILBUR MILLS, have discussed in detail the changes which this legislation would make in existing law and the new programs which it will place on the statute books. I do not, therefore, feel called upon to consume the time of my fellow legislators by repeating the details of what has already been so ably discussed. What I do hope to achieve by these few brief remarks is to instill in my colleagues a sense of the importance of this day to our times and to the future and the ramifications which this legislation will have in the months and years to come.

It seems, in one sense, that it has been only a brief period of years since I first sponsored this legislation even after those who had gone before me had worked for passage of somewhat similar programs. I well recall in the late 1940's and early 1950's the efforts of my esteemed late colleague on the Committee on Ways and Means, the Honorable John Dingell, whose distinguished son, I am proud to note, is now sitting as Chairman of the Committee of the

Whole House on the State of the Union who so proudly carries on today that oldtime Dingell tradition in the House of Representatives. I also well recall the courageous and extended battle fought for legislation similar to this by our colleague, the Honorable Aime Forand. In 1957, Aime Forand introduced what became known nationwide as the Forand bill, and he immediately became the target of extended and widespread abuse on the part of those who are today fighting the legislation which this House will pass.

From 1957 until this Congress, the Committee on Ways and Means on numerous occasions conducted hearings, both public and executive, on Aime Forand's bill and then, subsequently, on the similar legislation which I have had the honor to sponsor. In those hearings and some areas of the public press and in certain trade publications, I think all of you are aware that I became the target of a considerable amount of abuse. Perhaps only those Members who attended our most recent public hearings on this subject in the Congress just concluded will recall my comments when the representatives of the American Medical Association appeared and testified. At that time, I stated that what they had just said with regard to my bill was consistent with what they had been saying since similar legislation was first introduced and that the only real difference in their position was that a new set of figures had been devised to attempt to prove their case. At that time, I further recalled that the posture of opposition was one not unfamiliar to the American Medical Association since they had been consistent in opposing measures not only of this nature but also such laudable extensions of the Social Security Act as the Social Security Amendments of 1956 which for the first time provided disability insurance benefits. As I said at that time, I have never objected to fair criticism of anything which I have espoused, but the type of critical comment which was issued from some quarters of the American Medical Association far surpassed which we all except as within the bounds of reasonable critical comment.

However, I do not wish to dwell on that sort of thing. What I do want to do is to lend a sense of history to what we are doing today, by briefly reviewing the development of our social security system, and then to again say why this program in this bill is necessary.

HISTORY OF SOCIAL SECURITY PROGRAM

The 1935 social security legislation provided only old-age insurance benefits, and these were paid only to the worker himself. The amendments of 1939 put the protection of the program on a family basis by adding monthly benefits for the worker's dependents and survivors. Not only the aged and retired worker but his widow as well could therefore look to an assured but modest income in old age. The 1939 amendments also provided that the monthly benefits that were to be paid under the social security system should be paid beginning in 1940, and in this

way realized the potential of social insurance to provide full-rate benefits without awaiting the buildup of huge reserves many years in the future as under private insurance.

During the 1950's, adjustments were made in the benefits and the earnings base of the program that were needed to keep social security in step with our economy. Also, the coverage of the program was greatly improved during the past decade. In 1956, benefits were provided for disabled workers between the ages of 50 to 65. These benefits were, of course, made immediately effective for workers who had become disabled previously. In 1958 benefits were added for dependents of disabled workers; and in 1960 the law was changed to provide benefits to disabled workers at any age and to their dependents.

NUMBER OF PERSONS INSURED

At the beginning of 1965 over 92 million people had worked long enough to be insured under the program, with the result that 9 out of 10 people now becoming 65 will be eligible for monthly benefits under social security when they retire. In the years to come, over 95 percent of the elderly will be insured. The total number of people of all ages receiving monthly benefits is now about 21 million—more than the number of people who live in my State of California, our Nation's most populous State. Benefits now total over \$16 billion a year.

HEALTH BENEFITS A LOGICAL EXTENSION

While social insurance has evolved from a program of old-age security to one protecting orphans and their mothers and the disabled and their dependents, it still has its major impact in old age. Ironically, it is in the old-age security part of the program that the greatest gap in protection now exists—the absence of any provision for meeting large health costs.

Protection against the health costs in old age is a logical and necessary extension of the retirement protection furnished by the present social security program. Monthly cash benefits can meet the regular recurring expenses of food, clothing, and shelter but such benefits alone cannot give economic security in old age. It is also necessary that older people have protection against the unpredictable and unbudgetable costs of expensive illness. A person may go on for a long time with little in the way of medical expenses, and then in a very short period have a hospital bill running into thousands of dollars. Cash benefits are not a practical way to meet this need. The only way that effective retirement protection can be furnished is through a combination of a cash benefit and insurance against the costs of major illness. Our country's system of social insurance simply cannot do the job it was set up to do until it provides this dual protection.

The legislation now before us would close the last remaining gap in the social insurance protection of the older American. I am proud that I have been privileged to have introduced H.R. 1—as well as its predecessors—and thus to play a

part in bringing the needed health cost protection to our elderly citizens.

While virtually every committee member has contributed to the development of the health benefits legislation, one man, the gentleman from Arkansas, Chairman MILLS, deserves major credit as the architect of this monumental proposal.

As the Members of this body know, the chairman does not sponsor legislation which has not received the most careful and painstaking consideration. During the more than 7 years he has served as chairman of the Committee on Ways and Means, Mr. MILLS has seen to it that every piece of legislation bearing his name represents the best thinking, the best construction, the best techniques for dealing with the problem at hand. He has examined every view that has been offered in connection with this proposal by both proponents and opponents and explored with painstaking care every comment and criticism. All of this has been distilled with the intent to retain only the most constructive suggestions. The result is one which, like social security itself, embodies values and ideals with which few in this body can seriously dispute. The bill before us will, I am certain, be a lasting monument to Chairman MILLS' expertise, his energy, and his skill as a legislative craftsman.

We also owe a debt of gratitude to Secretary Celebrezze, Assistant Secretary Wilbur J. Cohen, Commissioner of Social Security Robert M. Ball, and Chief Actuary Robert J. Myers. These men worked diligently with the committee and were of great assistance in developing a proposal which would be socially desirable, medically and actuarially sound, and administratively feasible.

NATURE OF THE HEALTH BENEFITS PROPOSAL

The health benefits legislation recommended by the committee would utilize various resources which can, each in its own way, contribute the most to combat the insecurity that stems from high health costs in old age. The health insurance provisions of the bill would establish two separate programs—one basic, the other supplementary; one compulsory, the other voluntary; one financed through a special tax on earnings, the other financed through premiums and general revenue contributions.

The basic plan would provide hospital insurance protection for virtually all older people. Because of the relatively high cost of hospital insurance for older people, provision is made for workers to pay in advance, before they reach age 65, toward the cost of their benefits just as they now pay while working toward their cash social security benefits.

Coverage under the basic plan would be provided in a fashion like that of the present social security system, because hospital costs pose so widespread a threat to the economic security of elderly people that it should be certain that virtually all the aged will have hospital insurance protection. Medical expenses for hospitalized aged people are five times greater than for the aged not hospitalized. Nine out of ten aged people who

reach age 65 will be hospitalized at least once—two out of three, at least twice—before they die.

In addition to meeting hospital care costs, payments would be made under the basic program for less intensive services and levels of care appropriate to the hospitalized patient's needs as his condition changes, and which can be substituted in many cases for inpatient hospital care. These ancillary benefits would cover posthospital care in an extended care facility and posthospital home health services. In addition, outpatient diagnostic studies would be covered.

With the cost of the individual's old-age hospital benefit protection financed during his working years, he would be in a position to make a substantial contribution in old age toward the relatively low-cost supplementary protection which would be provided by the bill on a voluntary basis.

The voluntary supplementary plan would meet the costs of physicians' services and provide other benefits which are designed to build upon and fit together with the protection that would be afforded the aged under the basic hospital insurance program. The combined coverage of the two insurance programs would result in protection for the elderly of a quality that only a few older people can now afford.

Coverage of physicians' services would be a particularly valuable supplement to the hospital insurance provided under the basic plan. According to the National Health Survey, payments for physicians' services represent about 30 percent of private health expenditures for aged persons. The annual \$50 deductible under the supplementary plan would limit physicians' coverage under that plan to cases where costs are appreciable.

ADMINISTRATION

In developing the basic and the supplemental plans, a great deal of thought was given to their administration. The conclusions reached represent, I believe, a reasonable approach which promises to be efficient and, because of the selection of private organizations to carry out some of the more sensitive tasks, acceptable to the providers of health services.

In assigning administrative functions it was recognized that each of the services covered under the basic program is provided by institutions or organizations which are accustomed to receive payment on a cost basis for the services they furnish from Blue Cross organizations and from public agencies and programs. The committee concluded that it would be feasible to provide in the administration of the basic program for the use of fiscal intermediaries selected by hospitals and other providers of services.

This would permit the same organizations or agencies which now reimburse providers of services on a cost basis to be used to perform a similar function under the basic hospital insurance program.

On the other hand, the services selected for coverage under the supplementary plan are primarily those provided by individuals or organizations that are

paid for their services on the basis of established charges. The bill provides for payments to physicians on a charge basis to be made by private carriers under contract with the Secretary. The private carrier would have the responsibility for determining the amount that physicians and others who would furnish services covered by the supplemental plan should be paid.

While an important role would be reserved for private organizations, I fully expect the Department of Health, Education, and Welfare to exercise leadership in seeing to it that these federally financed programs are being carried out with efficiency, that the rights of beneficiaries and providers of health care are observed and that high quality in medical care for the aged is a primary goal.

BENEFITS AND BENEFIT BASE

While health insurance for the aged is the major achievement of this legislation, it is monumental also in its provision of improved protection for the totally disabled, in its recognition of the plight of the orphaned child of college age, in its improvement of the fiscal framework of the program by going far to reestablish a proper base of earnings to be taxed for its support, in its recognition of the need of the average and higher earners to have more of their earnings credited toward future protection, and in its great improvement in the provisions for medical and other aid to the poverty stricken of the Nation. For all these improvements, too, Chairman MILLS and others will deserve the gratitude of many.

CONCLUSION

Mr. Chairman, the health benefits proposal represents a practical solution to a particularly difficult problem. It would provide the extensive health cost protection that older people need—thus overcoming perhaps the strongest objection that our friends from the American Medical Association have raised in connection with some of the proposals with which I have been associated in the past.

This broad protection would be financed in a way that would enable the individual to contribute substantially to the cost of his protection. This contribution from the worker means that he can expect the benefits to be paid as a matter of right and in a manner that safeguards his dignity and privacy. Also, because the benefits and the contributions are so closely connected, an attitude of responsibility toward the cost of program changes will be preserved where they might have been lost had benefits been provided largely or entirely from general revenues.

Finally, the State-Federal programs of medical assistance for the needy aged, relieved of a substantial part of their burden and otherwise strengthened by the proposed legislation, will be better able to meet the medical needs and other needs of our indigent elderly citizens.

This three-way approach promises to make financial security in old age an obtainable goal for the great majority of older Americans in a way that should be acceptable to all. This monumental approach deserves the support of every Member of this House.

What greater satisfaction could there be for those of us privileged to serve in this distinguished body than to know we have provided a means of securing the benefits of the accomplishments and tremendous strides that have been made in modern medicine for millions of our elder citizens.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield 20 minutes to the gentleman from Missouri [Mr. CURTIS].

Mr. CURTIS. Mr. Chairman, I opposed the rule, before the Rules Committee and here on the floor, on two grounds: First, there is not the climate in this country or in this House to conduct an intelligent debate on this subject, and, second, because the House and the Committee on Ways and Means did not gain the knowledge, not having done the necessary research in this area, to conduct a meaningful debate.

I might add a third reason, that it is very obvious that this is not a debate. There is no decision going to be made in the well of the House. This is a farce. There are scarcely 100 Members on the floor of the House now. There were not 100 here at the time the gentleman from California [Mr. KING], the author of the bill, was making his remarks. There was not even a quorum of Members during the discussion of the chairman of the committee, for the simple reason—and this is not said in criticism, I might say of the Members of the House who are not present, although I might say it is a commendation for those of you who are here; it is not criticism for this reason—everyone knows that the decision has been made outside the well of the House.

The Congress in this instance is no longer a study and a deliberative body. This is a rubberstamp operation, just as we saw last week. These decisions have been made, possibly wisely or unwisely, through a different process for rendering judgments in our society. So I am not going to take a great deal of time indulging in this farce because what I might say, even though it might have merit and might bring out some wisdom, makes no difference, any more than what the chairman of the committee had to say makes any difference, or the gentleman from Wisconsin.

Mr. ARENDS. Mr. Chairman, I make the point of order that a quorum is not present.

The CHAIRMAN. The Chair will count. Eighty-six Members are present, not a quorum. The Clerk will call the roll.

The Clerk called the roll, and the following Members failed to answer to their names:

[Roll No. 68]

Ashley	Duncan, Oreg.	Roosevelt
Baldwin	Evins, Tenn.	Smith, Calif.
Berry	Jones, Ala.	Springer
Bolling	Mailliard	Stalbaum
Bonner	Moorhead	Steed
Daddario	Morrison	Sweeney
Dent	Powell	Teague, Tex.
Diggs	Rhodes, Ariz.	Toll

Accordingly, the Committee rose; and the Speaker pro tempore (Mr. ALBERT) having assumed the chair, Mr. DINGELL, Chairman of the Committee of the Whole House on the State of the Union, reported that that Committee having had under consideration the bill H.R. 6675, and

finding itself without a quorum, he had directed the roll to be called, when 409 Members responded to their names, a quorum, and he submitted herewith the names of the absentees to be spread upon the Journal.

The Committee resumed its sitting.

The CHAIRMAN. The Chair recognizes the gentleman from Missouri [Mr. CURTIS].

Mr. CURTIS. Mr. Chairman, before the rollcall I was making the point that, in my judgment, this matter was not ready for debate and deliberation on the floor of the House. The point is well made, because the Members themselves have already made up their minds as to what they are going to do; apparently they know what is in these 296 pages. In my judgment we do not know these things and we cannot, of course, move forward with any intelligent discussion of the bill.

There are reasons for that. The point was made by the gentleman from California [Mr. KING], and also during the debate on the rule by the gentleman from Indiana, that the propaganda of the American Medical Association had confused the issue. This point was raised in the Rules Committee, and I stated that perhaps there has been some confusion by this propaganda. But even a more serious problem is the climate created by the propaganda campaign which has gone on for years, financed, I would point out, contrary to the law, by Federal tax money and the use of Federal employees' time in order to promote it. I am referring to the action of certain employees of the Department of Health, Education, and Welfare. I have made these charges of lobbying with Federal funds on numerous occasions. I have documented them. There is no question but what the matter is confused as far as the public is concerned, and as far as the Members of Congress are concerned. The Government's propaganda is such that the people have been given a constant dose of misinformation rather than accurate information.

Let me go on to the second part, which is equally serious, and that is that this committee, the Committee on Ways and Means on which I serve, is not in a position to present accurate information to the House that will enable it to conduct an intelligent debate on this very important and controversial issue. As the gentleman from Wisconsin [Mr. BYRNES] stated, the issue of controversy, of course, is in the area of health care.

The Committee on Ways and Means did bring out a bill last year in regard to improvement of the social security program and, as has been pointed out, this passed the House almost unanimously. One part of this bill therefore contains matter about which there was adequate study and discussion in the Committee on Ways and Means. The committee was in a position to present that matter to the House for proper debate and its full consideration. But the controversial aspects of this present bill are not ready for debate and deliberation. That was very well demonstrated at the time the gentleman from Cali-

fornia [Mr. KING], had the floor, and the chairman of the Committee on Ways and Means [Mr. MILLS], engaged in a colloquy with the gentleman from Wisconsin [Mr. BYRNES], in regard to the cost estimates of one important health aspect of the bill. The gentleman from Arkansas [Mr. MILLS], referred to some later figures on cost estimates, dated around April 5, as I recall. I am a member of this Committee on Ways and Means, and I have never seen these new cost estimates. I might say I doubt if anyone else on the committee has seen these new cost estimate figures.

When we began hearings there were discussions behind closed doors on January 27. There has been a constant revision upward of the cost estimates, but all of this was done behind closed doors. The chairman of the Committee on Ways and Means knows I have a very high regard for him, although we have a fundamental difference of opinion on the procedures the committee followed in trying to look into the aspects of this very controversial issue.

I urged that there should be open hearings and people with knowledge in our society on this subject should be given the opportunity to come before us. This was not a military operation we were studying. This was a matter of public information, and it should have been of great interest to the public and to the press, if they have been inclined to report it, for example, to report the colloquy which went on between the actuary of the committee, for whom I have a great regard, and the actuary of some of the health insurance companies. And after this, the actuaries revise their estimates on this. But the public does not have any knowledge on this. Many of the Members of the Committee on Ways and Means know nothing about it. The Members of the House know little about it. The Members are permitted to vote for or against a label, not a piece of legislation.

Mr. HALL. Mr. Chairman, will the gentleman yield?

Mr. CURTIS. I yield to the gentleman from Missouri.

Mr. HALL. Is it not true that at one time the same actuaries' calculations for the original King-Anderson or administration hospital care bill were found by the chairman of the Ways and Means Committee itself to be 100 percent off base?

Mr. CURTIS. It is more than 100 percent. It is difficult trying to figure out what the costs in this area would be, and there is still serious dispute on the part of health actuaries as to whether we are still not underestimating the cost in the H.R. 1 part of the bill, let alone the cost in the Byrnes package, either as contained in the bill or the Byrnes package as contained in the motion to recommit.

Mr. HALL. Is that not true because we are dealing with service benefits instead of cash benefits?

Mr. CURTIS. That is the problem. We are fundamentally changing the concept of social security, one which has been a cash program, to one which is a hybrid, which includes cash and certain

services. But how can we estimate what services will cost over a period of years?

There were witnesses that we failed to hear. Let me pin this point down. The chairman of the committee told the House how many hours of hearings the Ways and Means Committee has had over the past years on this general subject. Indeed we have, but each time we held these hearings they were in relation to a particular bill. After we held the hearings we concluded that these were ill conceived proposals and did not stand up under the kind of testimony we received. So we have had version after version of King-Anderson proposals, we are now at about the tenth version. We have not had public hearings on this new bill, H.R. 1 the tenth version. No one who is knowledgeable on this subject has had an opportunity of testifying on it publicly.

It is true that we did call in a few expert witnesses—quite limited I might say—and there are some hearings now available, if the House is interested in looking at some of the testimony. This is quite limited testimony. But this is a far cry from calling in the very industries and professions that are responsible for our having the greatest health care system of any society in the world. Our problem in the field of health care for the aged, as I often point out, is not the result of failure—it is the result of success. We have been so successful in our society and in our methods of handling health care not just for the aged but for our entire society that people are living 10 or 15 years longer. It is success in this field that has created the problem—the economic problem that we are now trying to cope with. But it is not the failure of our health care system. It is its success. The people responsible are the drug industry, the hospitals, the doctors, the health insurance companies, the nursing homes, the visiting nurses, businesses or labor organizations with their pension plan programs. It is hard for this body to realize, I believe, that these groups most of which have opposed this kind of legislation and have recommended that we not move forward in this way were not permitted to testify before us so we received no benefit from their advice or their criticism under cross-examination—and I might add with the advice of rebuttal witnesses on the part of those who might disagree with them. This is the committee process. This is the way the Congress is supposed to gather knowledge and wisdom on an issue to apply it to its solution. But these were not the procedures that we followed and we do not have the benefit of the advice that these groups could give. The advice we have received has been received largely on an ad personam basis by the chairman of the committee, for which I commend him and to some degree by the gentleman from Wisconsin [Mr. BYRNES] and myself to a very limited degree to the extent that we could personally meet and talk with these people in our offices. But that is not the committee process. If the chairman of the committee wants to interrogate the top people in the Blue Cross in regard to a program, let him do so so that the

rest of us on the committee can get the benefit of those discussions because these are not easy matters. This is a committee process. But we are before the House today without that benefit.

Mr. LANDRUM. Mr. Chairman, will the gentleman yield?

Mr. CURTIS. I yield to the gentleman.

Mr. LANDRUM. I am reluctant to challenge the gentleman's statement.

Mr. CURTIS. I should think you would be.

Mr. LANDRUM. But I went to the committee this year as a new member and I participated in the hearings over there for a great number of days—I do not know just how many. But as I recall, there were between 2 and 3 weeks devoted to hearing experts from the insurance industry; Blue Cross and Blue Shield; the hospital association; the American Medical Association, which was represented by, among others, its president, Dr. Donovan Ward; the American Nursing Home Association, the pathologists, the labor unions, and so on. I do know that it took two rather thick volumes to print these hearings. In addition, we received a great volume of written communications including material from drug industry representatives, physicians, hospitals, and others.

Mr. CURTIS. Yes; I saw you there.

Mr. LANDRUM. And I listened intently and questioned for a little bit of the time officers from various carriers of insurance in particular, including Blue Cross and Blue Shield. I listened intently to the actuaries from that organization and to the president of that organization as well as to the actuaries from the insurance industry. I listened to what the Social Security Administrator and the social security chief actuary had to say and I heard the gentleman question them, and I listened to a lot of his questioning and received a great deal of benefit from it.

Mr. CURTIS. All right, I want to thank the gentleman. But the point I made is still accurate. I did point out that there were a limited amount of expert witnesses called in before the committee. I pointed it out, if the gentleman had been paying attention—and if he would pay attention now—that there were some limited hearings that had been published that would show some of this information. But I am trying to point out the procedures that did go on, and I know the gentleman would recognize this.

Mr. HALL. Mr. Chairman, will the gentleman yield?

Mr. CURTIS. I yield to the gentleman.

Mr. HALL. The gentleman mentioned the pharmaceutical industry being heard and their testimony being made a part of the hearings. I did not notice where they were heard to any extent or whether any part of the pharmaceutical associations were heard, yet I notice that there were the HEW experts testifying as to what the pharmacists thought. Were they ever given a chance to rebut it?

Mr. CURTIS. No; they were not. As a matter of fact, the committee sat there

throughout all of these executive sessions with the officials of the Department of Health, Education, and Welfare constantly present. The usual occurrence was for the HEW officials to state what the various industries—the pharmaceutical industry or the hospitals or the nursing homes or visiting nurses associations thought. Many is the time, and I think the record will show it, I said I am interested in interrogating these people myself and I chided the chairman of the committee on occasions when he said, "Here is what they told me." And I said, "But, Mr. Chairman, what I want to do is to interrogate them myself."

Mr. MILLS. Mr. Chairman, will the gentleman yield?

Mr. CURTIS. I yield to the gentleman.

Mr. MILLS. The gentleman from Missouri [Mr. HALL] raised a question about whether the pharmaceutical people appeared before the committee.

Mr. CURTIS. That is right.

Mr. MILLS. They did appear before the committee in connection with the hearings on the bill we had under consideration in 1963-64.

Mr. CURTIS. Yes.

Mr. MILLS. They did not appear in 1965.

I believe my friend from Missouri who is in the well of the House should call the attention of the gentleman from Missouri to the fact that the quarrel with the Pharmaceutical Association was over the fact that we had limited available drugs under this program to those drugs listed as being all right by the publications used in the professions or those that are passed on by medical staffs of hospitals. This is spelled out on page 24 of the report. They wanted to go beyond that, and we did not believe it appropriate to do so.

Mr. CURTIS. I might say to the chairman that there were many points they made. I read from a letter in the committee one of the points they did make which was ignored.

The chairman is verifying, in essence, the manner in which we proceeded. That is the very area as to which we have a quarrel and disagreement on procedures.

What I am trying to bring out for the benefit of the House, but also to make a record here in the CONGRESSIONAL RECORD, at any rate, is the procedures we did follow and why I am suggesting that this matter is not ready for debate on the floor of the House. We lack the information we should have acquired in public hearings if these knowledgeable people had been permitted to testify not on a general subject but on the specific proposals. There was H.R. 1, which was a new bill, 139 pages long, and the confidential print which the chairman had made up for the committee, of some 250 pages, which many of us had not seen until it came in. Under the orders of the chairman, this print was not to be taken out of the committee room. I told the chairman that I certainly intended to take it out, and to at least allow some of the people who had knowledge in this field an opportunity to comment on some of the language.

This is the procedure we did follow. I submit we are not in a position under these kinds of circumstances, for a measure of this importance, to move forward to debate it with intelligence.

Mr. JONES of Missouri. Mr. Chairman, will the gentleman yield for a question?

Mr. CURTIS. I yield to the gentleman from Missouri.

Mr. JONES of Missouri. Can the gentleman tell me upon whom we must rely for the estimates of the increase in the hospital patient load under either one of these plans?

Mr. CURTIS. Yes. It is essentially on the testimony of Mr. Myers and his associates. He is the chief actuary of HEW. In addition, the colloquys and conversations he in turn has had with some of the top actuaries of the health insurance organizations, all of this I might add was behind closed doors.

Mr. JONES of Missouri. My apprehension has been that I know, in the locality in which I live, our hospitals are filled to capacity all of the time. Observing the hospital insurance plans which are in effect, are we in danger of creating an obligation which cannot be met by the physical hospital facilities, under this plan?

The CHAIRMAN. The time of the gentleman has expired.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield 5 additional minutes to the gentleman from Missouri.

Mr. CURTIS. The answer to that question is, I believe there is a real danger. There is a real concern not so much over the facilities as over the skills; the available nurses and doctors.

Mr. JONES of Missouri. The nurses and technicians, but even the physical plant. I know that in my area we do not have sufficient hospitals to take care of any additional load at all.

Mr. CURTIS. That is a real concern of the limited facilities and one of the factors we need to go into.

I offered a bill which has been law for some time, to provide FHA guarantee for private nursing homes, which did produce about 100,000 beds and we are now building about 50,000 new beds capacity a year.

Mr. MILLS. Mr. Chairman, will the gentleman yield on that point?

Mr. CURTIS. I wanted to finish two or three points, but I will yield. The point is that we are not in a position to talk with intelligence, Mr. Chairman, because we did not call in the people who know the answers.

Mr. MILLS. My friend from Missouri and I can always talk with intelligence.

Mr. CURTIS. Not always. I cannot talk with intelligence without studying these things first. I try to, but what constitutes study?

Mr. MILLS. The work both you and I do.

Mr. CURTIS. We try to get knowledge from people in the particular fields of their excellence by interrogating them.

Mr. MILLS. On the point made by the gentleman from Missouri, I thought my friend believed as I have believed

over the years, that most of the people who need hospitalization and who need the care of a doctor, in your country and in my country and in the country that the gentleman from Missouri [Mr. JONES] serves, get it, whether they are in a position to pay for it or not.

Mr. CURTIS. That is correct.

Mr. MILLS. If they get it, then how does this bill which provides the means of making payment for these services bring about this undue overutilization which the gentleman is talking about?

Mr. CURTIS. The gentleman is fully aware of why, because we devoted a lot of time to this problem of hospital overutilization. The emphasis in this bill on hospital utilization boards and the concern many people express when we go to this kind of a program there will be this overutilization. However, let me go on to finish my points.

Mr. MILLS. All right.

Mr. CURTIS. All I am making a point about is this: I am not trying to engage in a debate on the substantive issues of this bill because we are not in a position as a committee to advise this House with any intelligence. We have failed to obtain the information and what information we obtained in the past we have not kept up to date. We do not know what we are talking about in this area. However, let me go on to the three other points that I want to make.

What concerns me so deeply about moving forward in this important area in ignorance is that we do not know; but this we do know: the payroll tax has a limitation, just as we have now found that the Federal income tax has a limitation, and we all recognize the economic damage it is creating.

Senator RUBIOFF, when he was the Secretary of Health, Education, and Welfare, advised this committee in one of our public hearings under cross examination that he was concerned with the limitation of the King-Anderson bill, which was to give benefits that were less than 25 percent of the cost to the older people. I said, "Why did you limit it?" and he said, "Even to pay for these we have to get the payroll tax to where it is 10 percent of the payroll, and when it reaches that it creates real danger for the social security system itself."

Now, this bill has 11.2 percent ultimately with a base of \$6,600. I tried to engage and I did engage in a limited colloquy with the Director of the Budget, Mr. Gordon, and I put in the RECORD, excerpts from the hearings, a colloquy on the economic consequences involved if we load too much on the payroll tax. The unemployment insurance system is based on that tax, too. In effect, so is workmen's compensation. We are moving ahead here without the benefits of the wisdom and the knowledge that experts in this field might have given us. Just because there is a popular label on this bill it will be passed. This is the kind of a climate that has been created, and in which we cannot conduct an intelligent debate.

The second point is the compulsion and the comprehensiveness of medicare. If you look at the bill, right at the very beginning there is a great big label on

page 9. It says "Prohibition Against Any Federal Interference." It says there will be no Federal interference, and that free choice by the patient is guaranteed. Then the next 70 pages tell you how the Federal interference will be carried out. Let us not kid ourselves about it. It has to be. I am not arguing against that. If we use Federal funds, we have to have Federal regulations. The provisions are that the Department of Health, Education, and Welfare must enter into contracts or agreements with hospitals and nursing homes, and if your nursing home or your hospital which you want to go to does not agree with the officials in Washington on their charges and what they can charge for, then the older person cannot go to that hospital or nursing home.

The CHAIRMAN. The time of the gentleman has expired.

Mr. BYRNES of Wisconsin. I yield to the gentleman 5 additional minutes.

Mr. CURTIS. Then the older person cannot go to that hospital. Where is the ultimate decision in the event of a controversy between the hospital board or the nursing home and the great Department of Health, Education, and Welfare? The ultimate decision is in Washington. There is a lot of machinery in between provided, of course, but in the event of a difference of opinion, the ultimate decision is vested, as it has to be, in the Department of Health, Education, and Welfare. I am happy that I was able to improve this bill to some degree by getting judicial review. So that there could be at least an appeal to the courts from the arbitrary decisions of the Department of Health, Education, and Welfare. So we have the basis for what many of us believe will lead to socialized medicine, moving into a socialization in this area.

My concluding remarks are these: In our society we have always taken care of those in need. The Kerr-Mills Act took this approach.

The American Medical Association has not been falsely propagandizing eldercare by saying it will provide up to 100 percent of medical cost. Eldercare is really only a modest improvement of Kerr-Mills. In my judgment it probably would only cost about \$100 to \$200 million in addition to what we are doing under Kerr-Mills. Kerr-Mills, which has been so badly misrepresented by the officials of the Department of Health, Education, and Welfare actually was saying this: We know the people on relief now are being cared for. However, there are some people who are not on relief. They own their own little home, have their pension, but if they get hit with a major medical cost, they could be thrown on relief.

Kerr-Mills in effect says to the States: You tell those people to bring in their medical bills and we can take care of them up to 100 percent if that is what they need, so they stay off relief.

Right, Mr. Chairman? Is not that the thrust of Kerr-Mills, so people would not go on relief? It is not the other way around, and so what eldercare says is this: Let us not wait until these people get hit with a major medical. Let us cover them with health insurance, and

if they have difficulty in meeting the premium cost then we can help them to pay the premium. This is the approach, and why eldercare and Kerr-Mills is really not very costly. It is taking care of up to 100 percent of all the medical costs. But it only relates to 15 or 20 percent of the older people in our society. But this compulsory program in the bill before us is to cover 100 percent of our older people—the rich, the medium income, as well as the poor, whether they can afford it or not, and cover about 25 percent of their average health costs.

As the chairman of our committee has often pointed out—and I agree with him—we should not use general revenues for welfare matters unless we have a means test; because, if we ever went to that there would be no end to it. That is why I am pleased that in the Byrnes bill, in a limited way—not the way I would like to, because it is too lush a means test—but at least we do say that in using general revenues as to people over \$5,000 of income there shall be a recoupment.

My concluding remarks are those that I began with, that this matter is not ready for debate. It is obvious that this House is not in a mood to debate and deliberate. The decision which was made outside of the well of the House, outside the deliberative process, is going to prevail. Members have already made up their minds. They are voting on a label.

What the chairman of the committee might say—and he is eloquent and is a student and I have great respect for him; and what Congressman BYRNES might say, and I have a similar respect for him, or what I in a small way might say, or the author of the King-Anderson bill, Mr. KING, might say, makes no difference.

Is it not obvious, Mr. Chairman, what has happened? The Congress of the United States has become a rubber-stamp.

Mr. Chairman, under permission to extend my remarks, I am including a discussion of another point in the bill, namely the amendment to the disability program.

AMENDMENT OF DISABILITY PROGRAM

During the committee discussion of the medicare legislation the processes for procedural and substantive action, namely the hearings and public discussions of the proposals contained in the legislation, were so lacking that many important changes were made without proper consideration.

To illustrate, Mr. Chairman, I refer to the committee action in changing the definition of disability in the Social Security Disability Act system. The definition under the present law declares a person eligible for benefits if he has an impairment "which can be expected to result in death or to be of long continued and indefinite duration." The amendment in the bill would make a person eligible for benefits if he suffered a total disability for a period of 6 months.

This change would affect thousands of persons and cost additional millions of dollars. In fact, the Social Security Administration estimates that 155,000 persons—other sources estimate a much

higher figure—will be added to the disability rolls immediately upon enactment of this amendment. The important national effect and import of this amendment apparently was unimportant to the sponsors because no public notice nor any public hearings at any time have been made upon this subject.

The additional cost of this disability definition change was never considered in the financing of the medicare legislation although a great amount of time and thought was given to the matter of adequate financing of other aspects of the bill. This change made in the last several days of committee meetings with its additional millions of dollars of cost will serve only to make the original finance figures more unreliable.

Furthermore, such a change in adding thousands of persons to the disability rolls will compound the injury already being done in the State workmen's compensation programs by the lack of coordination in Social Security Disability Act. Since 1958 disabled persons under the Federal and State programs have been receiving dual benefits as a result of the repeal of the offset provision in the act that year. Prior to repeal the Federal disability benefits were reduced by amounts received under the State workmen's compensation programs. These dual benefits generally exceed the take home pay of the worker which he received as an able-bodied working man on the job. It is a simple deduction then that by changing the disability definition and bringing more persons into the category of receiving dual benefits, the Federal program reduces the effectiveness of the State programs. Already some States have acted upon the suggestion of those in the Federal Government to reduce the benefits under the State programs by the amounts received from the Federal Disability Act. I do not believe that the Congress in its creation of the Social Security Disability Act ever intended it to water down or replace the State programs—yet, this is the actual happening.

The area of most serious concern is the rehabilitation of the disabled persons. Those most experienced in the field of rehabilitation point out that motivation is the key factor in bringing about rehabilitation. There is no question that cash benefits greatly motivate a person's desire to be or not to be rehabilitated. Commonsense dictates that a person receiving more income while disabled than when on the job will minimize, if not eliminate, the incentive to be rehabilitated. Opening up the disability rolls to thousands of additional persons without careful study and control will increase the difficult problems inherent in the rehabilitation programs.

An argument has been made by the proponents of social security replacing the State programs that the cost is on a 50-50 basis. Once the benefits become high enough, this method of sharing does not hold true. Witness the Italian program where 52 percent of payroll goes for social benefits and the employer pays

42 percent and the employee pays 8 percent of the costs.

Also in some countries, notably England, where the workmen's compensation program has been nationalized, the right to sue at common law by the employee against the employer has been made available again. Under the State compensation programs the employee gives up his common law rights to sue the employer for any injury received on the job in exchange of a definite amount of compensation. Should the State programs in this country be superseded by the Federal program, there is every reason to believe that we will return to the chaos, confusion and suffering that existed under the common law operation. I believe that such a development will have both labor and management up in arms all over the Nation against the possibility of such a happening.

There have been some statements that under the present definition, doctors cannot easily determine a total and permanent disability of long duration. However, doctors under the State programs have been able to make such determinations medically, conveniently, and wisely for 50 years.

It is also argued that the present definition creates hardship cases. Informed persons in this field tell me that proper administration and the courts in their rulings take care of any hardship cases which may arise and whenever we draw a line there will be argument, and properly so, as to just where the line should be. This is inherent in all legislation.

The report of the committee calls for the Health, Education, and Welfare Department to make a study of this problem and report no later than December 31, 1966. The Social Security Advisory Council made a recommendation for a study of this problem area in its report last year. It is amazing in the light of these two recommendations that the committee would legislate prior to the findings of the study rather than afterward. It is inconceivable that action would be taken prior to the fact rather than after the fact.

(Mr. SCHNEEBELI asked and was given permission to extend his remarks at this point in the RECORD.)

Mr. SCHNEEBELI. Mr. Chairman, I join my Republican colleagues in supporting many of the provisions in the social security bill. Like them, I have felt that many of these amendments are long overdue.

I am in full accord with the amendments in the bill that would increase benefits by 7 percent across the board with a \$4 minimum increase for a worker, continue benefits to age 22 for certain children in school, provide tax exemption of certain religious groups, provide actuarially reduced benefits for widows at age 60, and pay benefits, on a transitional basis, to certain persons currently 72 or over now ineligible; liberalize the definition for disability insurance benefits; and, increase the amount an individual is permitted to earn without suffering full deductions from bene-

fits. These social security amendments were agreed upon by the conference committee in the 88th Congress. A bill containing these amendments could have been enacted long ago, and with unanimous support on the part of the Republican members of the committee.

During the consideration of the so-called King-Anderson bill—H.R. 1—in the 88th Congress, the Way and Means Committee also tentatively agreed upon amendments to improve and enlarge the Kerr-Mills Act. I am glad to find these amendments in the bill. I am certain that the committee would have reported out similar amendments last year, except for the fact that the proponents of medicare—lacking support for their program—asked that the committee pass over all amendments dealing with medical care for the aged. These Kerr-Mills amendments would be in the law today, with the full support of the Republicans, were it not for that fact. I know that these amendments will enable my State—the Commonwealth of Pennsylvania—to improve its already extensive Kerr-Mills program.

There are other fine amendments in the bill providing for medical aid to dependent children, the blind, and the disabled; services for maternal and child health, crippled children, and the mentally retarded; and a 5-year program of special grants for health services for children. I fully support these amendments.

I also have no objection to the voluntary program of supplemental insurance added to the original medicare proposal. The Republicans have consistently pointed out that the original hospitalization program proposed by the administration was wholly inadequate. This inadequacy would have resulted in deception and confusion for some 18 million of our elder citizens—the overwhelming majority of whom had been led to believe that the so-called medicare bill, H.R. 1, provided what that term implied; namely, complete medical care.

Not only do I find nothing wrong in the voluntary approach to insure the elderly for doctors' charges and other medical services, I believe that the bill would be immeasurably better if that concept had been applied to the entire hospitalization program.

Our committee should take pride in the fact that with the exception of the compulsory payroll deduction aspect, the bill has broad support among Democrats and Republicans alike. Why should we have this one large negative feature in the bill—and by this I refer to the hospitalization program—financed by a payroll tax automatically and compulsorily extended to everyone over age 65 regardless of need. In using the term "need," I do not refer to a "needs test" or "means test." I refer to the fact that there are many of our elder citizens who are already being covered in increasing number at no cost to themselves under adequate programs of group health insurance, provided for by their employers, their unions, or by other organizations. Those people have no need for a Govern-

ment program; for them, it is superfluous.

In opposing the financing of the hospitalization program, I am not unmindful of the increased cost of health insurance for those over age 65. On the contrary, I believe that the comprehensive health insurance program embodied in a bill which I introduced—H.R. 4354—and in similar bills introduced by other Republicans, will provide more adequate health insurance for the aged, at a lower cost, and without imposing a regressive payroll tax upon tomorrow's workers.

The payroll tax is one of the most unfair and regressive taxes in the entire Federal tax system. It applies to the first dollar of earnings. There are no exemptions, no deductions, no exclusions, and no tax credits. The president of a large corporation pays the same tax as his workers earning as little as \$5,600 per year.

Under the committee bill, a worker earning a mere \$3,600 wage, with a wife and two children to support, will be taxed on his first dollar of earnings—not for his future benefit—but to pay current hospital benefits for a retired couple with the same or more income, who pay no Federal taxes at all. I just do not think that this is fair and proper.

Under the tax rates in the committee bill, a 21-year-old worker and his employer will pay the equivalent of \$8,590—during the employee's working years—and those rates may be inadequate.

Under the Republican program a participating individual will pay only when he reaches age 65—not for 44 years in advance—and under present assumptions he can expect to pay \$874.50 in premiums during his retired years. Although this figure is only about 10 percent of the amount that must be paid on behalf of an individual worker, under the committee bill the benefits greatly exceed those financed by the committee's compulsory social security program.

Not only does the Republican proposal avoid this regressive payroll tax, but on the other hand its voluntary aspects and broad coverage provide additional advantages over the committee bill.

The basic hospitalization program in the committee bill is extended to all eligible persons over age 65 automatically and compulsorily.

The Republican program would be wholly voluntary. When coupled with the payment of a premium contribution, this reduces the duplication of coverage for those already covered under private programs. It preserves the insurance concept.

The Republican program requires the participants, including those presently over age 65, to make a contribution toward the cost of their insurance. This reduces the cost which is passed on to taxpayers under age 65. It also acts as a deterrent to excessive utilization of benefits on the part of those enrolled.

The hospitalization program in the committee bill is, in fact, a part of the social security tax system. An additional liability of \$133 billion is imposed on the social security tax structure by the adoption of that program.

The Republican program is financed wholly apart from the social security system. It does not jeopardize future increases in cash benefits.

In financing the hospitalization program through the payroll tax, as a part of the social security system, the committee bill gives rise to the concept of "entitlement." It creates the erroneous impression that the wage earner is "prepaying" for a specific hospital benefit. This precludes any revision of benefits in the future, except to increase the scope of the program.

The Republican program preserves a high degree of flexibility. When the insured is required to pay a premium for the benefits, both premiums and benefits can be modified as the need arises. Pressures for increased benefits will be minimized if such increases are charged against the insured through higher premiums.

The committee bill does not meet the problem of catastrophic illness. Benefits of the combined hospitalization program and medical services program in the committee bill fall short of the benefits provided for in the Republican program.

The Republican program covers the catastrophic illness up to a lifetime maximum of \$40,000 in benefits. The Republican bill also covers prescribed drugs, while the committee bill excludes this item.

By eliminating duplication of coverage and combining all medical benefits in a single comprehensive insurance program, the Republican program will provide more protection for less dollars.

The Republican proposal provides for premium contributions related to cash benefits under social security, coupled with a tax recoupment of the subsidy attributable to individuals with incomes of over \$5,000 and married couples with incomes of over \$10,000. This eliminates "need" as a basis for qualification without extending benefits to those who are, in fact, able to pay the full cost of their own insurance.

The Republican proposal also incorporates the amendments to the social security laws proposed in the eldercare bills, thus making more specific the right of the States to enter into private contracts of insurance to cover the State-administered OAA and MAA programs.

I am also critical of the committee bill in another respect—not for what the bill does—but for what it fails to do with regard to the overcharge on the self-employed.

On several occasions, I proposed that the committee amend the social security tax schedules in order to remove an obvious inequity with respect to the self-employed. Under existing law—and under the schedules in the bill—the self-employed will be paying 1½ times the tax paid by the employee for the same benefits. I have not been able to get a reasonable explanation for this difference.

Time and time again, we have been told by the Department of Health, Education, and Welfare that the tax paid by the employer should not be credited to or attributed to any individual employee. The Department takes the position that

the employer's tax should be treated as a part of the general fund to finance benefits for those who have only paid a nominal social security tax. If we accept that proposition, there is even less basis for taxing the self-employed any differently than we tax the employee. The self-employed is the "forgotten man" in our payroll tax structure.

This extra tax on the self-employed becomes particularly onerous as the tax rates increase. Under this bill, a self-employed person whose earnings equal the tax base will over his productive years—age 21 to 65—have paid total social security—OASDI—taxes of \$19,712 as compared with taxes of \$13,467 paid on the same wage base by an employee. When compounded at 3½ percent interest—the rate used by the Department—the self-employed OASDI tax comes to \$45,032 compared with \$30,679 for the employee. Forty-five thousand dollars is a lot of money to a small farmer, a small shopkeeper, a member of the clergy, a barber, and the many millions of self-employed in our service industries.

This additional tax on the self-employed cannot be justified either by the benefits they receive or by their ability to pay. Benefits are the same both for the self-employed and the employee. In the payroll tax, ability to pay is completely disregarded. The president of a large corporation pays only two-thirds the tax of the self-employed barber—and we can be certain that there are more barbers, small shopkeepers, filling station operators, and the like, than there are affluent professional people among the self-employed.

Of the approximately 7 million taxpayers who file returns as self-employed, more than one-half report adjusted gross income of less than \$5,000 per year. This is the group which pays 50 percent more in social security taxes than do the executives of our large corporations. They are the farmers, ministers, barbers, taxi owners, filling station operators, small grocers, newsstand operators, and the like. Many have no employees at all, other than occasional family or part-time help.

A minister in my district wrote:

So far this year I have paid or owe \$587 in taxes on my 1964 income (which is slightly over \$4,800). This total figure for taxes includes \$139 in local taxes, \$189 in Federal income tax, and \$259 in social security tax. The figure, of course, does not include the Pennsylvania sales tax and the various hidden taxes.

There are three children in our family (the youngest is 5 years of age and the oldest, 12 years of age). I find it extremely difficult at the present time to set aside one-eighth of my income to cover these various taxes. If the social security tax is increased, the payment of the increase will not only be extremely difficult, but it will become virtually impossible without depriving the five members of the family of adequate food, clothing, and dental and medical care. Doubtless many other clergymen and other persons classified as self-employed find themselves in this same predicament.

In rejecting my proposal that we take action in this bill to remove the penalty on the self-employed, I was told that it would cost too much. I am not im-

pressed with the answer. Actually, the initial cost to adjust this tax would amount to 0.05 percent of payroll at a \$5,600 base. With the projected increases in both the tax and wage base, which are provided in the bill, I am confident that the shifting of this extra burden—now paid by the self-employed—to all wage earners and employers, including the same self-employed, would not have a significant impact on the social security trust fund. And this impact could well be spread over a period of years, just as the committee bill spreads the cost of increased cash benefits and the cost of the hospitalization program.

The additional tax to finance the health insurance program provides the same rate for the employer, the employee, and the self-employed alike. If the principle of this new tax is right, there is no justification for continuing to tax the self-employed at a much higher rate to finance cash benefits.

I earnestly hope that the other body, on passage of the bill, will face up to this problem. The self-employed need help; and all I ask is that they be given the same consideration as everyone else.

Mr. MILLS. Mr. Chairman, I yield 10 minutes to the gentleman from Missouri [Mr. KARSTEN].

(Mr. KARSTEN asked and was given permission to revise and extend his remarks.)

Mr. KARSTEN. Mr. Chairman, my colleague from Missouri complains that the decision on the medical care bill was made outside of this House. The gentleman from Missouri and I do not often agree, but I am inclined to agree with him to a certain extent in this instance.

Under our system of government it is the people themselves every election who determine the kind of government we shall have and how much government we shall have. By the largest majority in history the people last November elected a President who campaigned on a program of medical care for the aged. And, the Committee on Ways and Means in reporting this bill is carrying out the wishes of a great majority of the American people.

Now, Mr. Chairman, insofar as hearings are concerned it has been my privilege to serve on the Committee on Ways and Means for over 10 years. To my personal knowledge medical care for the aged has been the subject of public hearings at almost every session during that period of time. In the current session there are two volumes of hearings consisting of 898 pages of testimony. If there is one matter that has been thoroughly discussed by the Committee on Ways and Means, it has been the subject of medical care for the aged.

Mr. MILLS. Mr. Chairman, will the gentleman yield?

Mr. KARSTEN. I yield to the gentleman from Arkansas.

Mr. MILLS. Is the gentleman from Missouri making it clear that those two volumes of hearings consisting of 898 pages occurred at this session?

Mr. KARSTEN. I made that statement, Mr. Chairman, and we have had a similar record for almost every session of

Congress since I have been a member of the committee.

I am glad that the moment is at hand when the House of Representatives will have an opportunity to vote on legislation to provide medical care for the aged.

The struggle for a program of this kind began about 20 years ago. There have been outstanding advocates like the late John Dingell, our former colleague, Amie Forand, and more recently, our distinguished colleague, the gentleman from California, CECIL KING. On the other side of the question we have also had humane and considerate men but their views and their approach to this problem set them far apart from the advocates. This resulted in a stalemate on legislation to provide medical care for the aged, with the votes on the Committee on Ways and Means pretty evenly divided between those for and those against.

Stalemates have to await the arrival of a peacemaker. So it has been in this case. The distinguished chairman of the Committee on Ways and Means, the gentleman from Arkansas, has been the peacemaker. He has brought together the divergent viewpoints of the present as well as the past, and the bill before us is a tribute to his ingenuity, skill, and dedication to a task which seemed almost insurmountable.

Perhaps there are still imperfections in the legislation but I believe it is far better than any single bill heretofore introduced in the House. This measure is a consolidation of the best of all that has gone before. While the many provisions in its 296 pages are complex and technical, basically the legislation establishes the principle of providing a way for our elder citizens to take care of their major health needs.

The bill is divided into four principal parts. First, it provides a basic insurance program of hospital care based on H.R. 1, the King-Anderson bill. This will be financed in a manner similar to the regular social security program, by a tax on employees and employers. This program will provide 60 days of hospitalization and related nursing home service for all persons when they attain the age of 65.

The second part is voluntary and it covers doctor's fees in and out of the hospital. Aged persons who elect this coverage will pay a \$3 monthly premium which can be deducted from their social security cash benefits and this will be matched by a similar contribution from the Government. Hospital and medical benefits under these programs will be available beginning July 1, 1966.

The third major provision of the bill includes a 7-percent increase in social security monthly cash benefits. Under this provision, no primary beneficiary will receive less than a \$4-a-month increase so all of the aged may purchase the optional medical program with no loss of income.

Finally, the bill makes many substantial improvements in the Kerr-Mills program and also includes more liberal financing of health care services to needy children, the blind, and the disabled. It also strengthens and expands

the maternal and child health and crippled children's programs.

As good as this bill is there are still some who oppose it. I have read the Republican minority report and to me the conclusions are not surprising. The minority report declares that the health care plan for the aged is too costly, inadequate, illusory and some kind of a terrible threat.

The reason I am not surprised at the minority report is that these are the same charges the Republican Party has been making since the inception of the original cash benefit social security program in 1935. It was my privilege to serve as a House committee employee at that time and I well remember the dire predictions of the Republican spokesman on social security both in and out of Congress.

There was the late Allen T. Treadway, of Massachusetts, the then ranking minority member of the Committee on Ways and Means. Here is what he had to say on February 2, 1935, on the general subject of social security:

The greatest single threat to recovery * * * many businesses * * * probably will be unable to continue in operation.

Then there was the late Harold Knutson, who later became chairman of the Committee on Ways and Means. Here is the gloomy prediction he made in the well of the House on April 12, 1935:

The passage of this proposed legislation will further and definitely increase unemployment.

Mr. Knutson felt so strongly against social security that in the minority report he amplified his views with this condemnation of the social security program:

There are certain provisions of this bill so obnoxious to me that I cannot support it. * * * The measure is wholly inadequate. * * * The two payroll taxes which the bill imposes will greatly retard business recovery by driving many industries, now operating at a loss, into bankruptcy.

The late Republican minority member, Daniel A. Reed, of New York, who like Mr. Knutson before him, also became chairman of the Committee on Ways and Means, described social security this way:

The lash of the dictator will be felt. And 25 million free American citizens will for the first time submit themselves to a fingerprint test and have their fingerprints filed down here with those of Al Capone and every jailbird and racketeer in the country.

Our former colleague, John Taber, of New York, made a stirring speech on the floor on April 19, 1935, and here are his kind words about the social security program:

Never in the history of the world has any measure been brought in here so insiduously as to prevent business recovery, to enslave workers, and to prevent any possibility of employers providing work for the people.

Republican opposition to the principle of compulsory social security was not confined to the Congress. There were many otherwise responsible Republican leaders going about the country making speeches condemning the entire social security program.

Here is a copy of the New York Times, for November 1, 1936, and listen to what

the Republican National Committee chairman, John D. M. Hamilton, had to say about social security:

HAMILTON PREDICTS TAGS FOR WORKERS—REPUBLICAN CHAIRMAN WARNS THAT NEW DEAL WOULD REGIMENT 27 MILLION

If the Roosevelt administration is returned to power * * * 27 million men and women * * * will be forced to report to a politically appointed clerk. * * * In European countries, people carry police cards and are subject to police surveillance. So far, American citizens have not been subject to these indignities.

If Chairman Hamilton was not speaking for his party, perhaps the Republican candidate for President, Alfred Landon, was on September 27, 1936, when he had this to say. Here is a copy of the front page of the St. Louis Post-Dispatch for that date. Let me read the major headline: "Landon Calls Social Security Act Cruel Hoax on the Worker—Urges Repeal of Compulsory Old-Age Section of New Deal Program as Unjust and Stupidly Drafted."

A few weeks later, he came to St. Louis, and told us more of what he thought about social security. Here are the choice remarks he made in St. Louis which were reported in the Post-Dispatch for November 1, 1936:

How could any administration keep track of these 26 million of our fellow citizens? Imagine the vast army of clerks that would be necessary. Imagine the boost for bureaucracy. Imagine the field open for Federal snoopings. Are these 26 million going to be fingerprinted * * * or are they going to have identification tags put around their necks? * * * We must repeal the present tax on pay envelopes.

But let us return to the present. The minority report indicates our Republican friends today are trying to make the same mistakes as our late and former Republican colleagues of the 74th Congress. The real basis of Republican opposition today is the role of the Government in collecting a compulsory tax and serving as trustee for the aged. That is the same principle the Republicans opposed 30 years ago. I hope my friends on the left of the aisle will profit by the mistakes of their predecessors and I urge them to vote for the bill.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield 10 minutes to the gentleman from Virginia [Mr. BROYHILL].

Mr. BROYHILL of Virginia. Mr. Chairman, I want to repeat what has already been said in abundance on many occasions this afternoon, and will be said repeatedly before we conclude debate on this bill, and that is I, as well as most Members, support many of the provisions contained in this bill we have before us for consideration. In fact, I advocate the passage of many of these provisions as being not only desirable but necessary. I will go further and say that I support all of the broad objectives of this legislation if those objectives are to liberalize and broaden the Social Security Act. We approved a similar bill last year with a number of these same provisions in it. I also support any effort to correct some of the inequities that exist in the Social Security Act and that always exist in a law such as this that is so far reaching.

I support the objectives of this bill if it means we are trying to provide adequate, the best possible, health and medical treatment to all people over 65 who cannot afford adequate medical treatment. I am for providing this medical help without any embarrassment or humiliation to them; in other words, to eliminate all suffering, among all people, for that matter, and certainly for those over 65 which is the age group covered by this bill.

I support those objectives. All of us do. And we should support it. I think most of the people think that these are the objectives of this legislation. That is the reason why it has such broad support among the American people. But I feel that this legislation we have before us fails to meet those objectives.

This brings up a very interesting thing about our political system. It may be a good thing. That is, that all of us may see a problem which exists. Some see it a little earlier, some a little later than others. Some see the problem from their own point of view. But all of us can agree that a problem exists and that something should be done about it, that a solution is desirable. In fact we can agree that a solution is necessary. But we can disagree and honestly disagree as to what is the best method of solution or the best plan of solution.

Yet, under our political system we often shout and charge that the fellow that does not agree with our own method of solution, or has another plan or method, is not sympathetic to the problem or is not aware that the problem exists. Of course, some of us are often too anxious to claim the political credit for coming up first with an answer to the problem rather than finding the best answer.

I believe that is the situation that may cause some of the difficulty in the consideration of this bill. It has been said and agreed to before by both the chairman of the committee and the ranking minority member that a problem does exist in this area and that the people over 65 need help in arriving at a better solution of this problem. We all agree therefore a problem exists in this area, but we do disagree as to the method of approach. I disagree and seriously disagree with the approach for a solution contained in this bill, but I do not question the honesty and sincerity of any of the supporters of the bill. I commend the Committee on Ways and Means for the work they have done, the detailed and thorough manner in which all parts of the bill were considered. This thorough procedure was discussed by the gentleman from New York [Mr. KEOGH] earlier in the day.

I was impressed by the amount of time taken by the committee in discussing every detail of the bill. I found it difficult to be at all the committee hearings because they met so often. They met morning and afternoon, day after day. I will admit that many alternatives were discussed in the committee deliberations even though public hearings were not held this year as some of us felt should have been. All alternatives were considered, all amendments

were considered but most of them, particularly those offered by the minority side, were voted down. My objection or criticism is not against the Committee on Ways and Means or the way it considered the legislation but against the plan contained in the bill.

I hope that my criticism will be considered as constructive criticism, because we are concerned, seriously concerned, that this bill does not contain the best solution to this problem. We feel that it will not solve the problem as we would like to have it solved. We feel it would injure the medical services and conditions we enjoy here today. There is no finer medical system anywhere in the world.

It was said earlier that the old-age, survivors, and disability insurance provisions in the bill is noncontroversial. There was a little give and take in the committee's consideration of that part of the bill. It did not go so far as some of us wanted it to go. It went a little further than others wanted it to go in other parts of the program, such as bringing doctors under the program, and tips. By and large however, it was a package all of us could support. The provisions of the bill which are amendments to the old-age, survivors, and disability insurance program, are listed on pages 2 and 3 of the report. Therefore, a detailed discussion of these provisions is not really necessary.

But I would like to discuss the treatment of the Federal employees in this bill—or maybe the mistreatment of the Federal employees. We have for many years in the Congress, and I understand in the Committee on Ways and Means, been discussing the relationship between the social security system and the civil service system. The question we have been asked repeatedly is: Are Federal employees being treated fairly by not being brought under the social security system? The question has been asked if they were brought under the social security system, would it impair the civil service retirement system, and because of the fear that it might impair the civil service retirement system, Federal employees by and large have not pushed and insisted on being brought under it.

Many of us feel they should be permitted to come under it voluntarily and therefore have the same additional benefits as other employees in private industry, and I have actually introduced legislation in order to have this matter formally brought up before the committee. But I will confess this is a most complicated problem and needs a great deal of study. In fact, on page 103 of the committee report, it makes reference to the fact that in 1960 when the Committee on Ways and Means was considering the social security amendments, they discussed the problems of the relationship between social security and civil service and directed the executive branch to make a study of this particular problem and report back to the committee. Interestingly enough, that report came back to the committee just before we took final action and final consideration of this bill—actually, too late

to have the benefits of that study that took 5 long years.

In the meantime we are told that the executive branch wants to make a complete study of the civil service retirement system before any further action is taken by the committee in this area and a report is due from them on December 1, 1965.

But the committee did recognize that there was a gap in the relationship between social security and civil service that did need immediate action. That was the group of Federal employees who have less than five years of service. Under the present civil service system, an employee does not have and is not entitled to civil service benefits during the first 5 years nor does his survivor in the event of death become entitled to any survivorship benefit. Yet, during those 5 years he is having withheld for retirement, whether he likes it or not $6\frac{1}{2}$ percent from his pay. We feel, and the committee felt, that these people during the first five years should be brought under social security automatically in the event they left, resigned or retired from the Federal service or died within the first 5 years. The funds are there. The funds can easily be shifted from the civil service retirement system to the social security system and it would cost the Federal Government no extra money. So we would then treat Federal employees equal with employees in private industry.

As I said, the committee did discuss this proposal and the committee favorably considered it. It would be in the bill at this time except that there was a technical problem of drafting the language of the amendment. We had been on the bill for many months and we were coming to the conclusion of our deliberation. The technical language of the bill had to be drafted and the report had to be written. It was feared the additional time required to draft the technical aspects of this amendment might delay the bill being brought to the floor. So for that reason this provision was not included in the bill. I regret this action and this decision was not discussed in detail in the report. But the minutes of our executive session, I am certain, will show that. I am bringing it up here now to make it abundantly clear in the RECORD the intention and the desire of the committee on this subject. I therefore can assure the membership of the House that the committee would be willing to take action on it in the very near future.

If I have stated the situation incorrectly, I would be very happy for any member of the Committee on Ways and Means to stand up and correct me at this time. But that is the impression I have and I want the RECORD to show that was the action taken by the committee. In fact, this afternoon the gentleman from New York [Mr. KEOGH] and I introduced a bill that would accomplish just the objective that I have been discussing here for the past few minutes.

We did include in the bill a similar provision to bring the substitute schoolteachers of the District of Columbia school system under social security. Up to this time they have been excluded.

We have heard a great deal about the Federal employees who retired after 1960 not being included in this legislation. On top of page 23 of the report, in the paragraph near the top of the page, Members will notice that the only people excluded from the basic medical benefits of this bill are aliens who have not resided in the United States for 10 years, some subversives, and Federal employees who retired subsequent to July 1, 1960. That is a grouping which I am sure the Federal employees will not like.

We did, however, include the Federal employees who retired prior to July 1, 1960. That was not proposed in the original bill. That was included as a result of an amendment in the committee.

Why did we bring those who retired prior to July 1, 1960, under the act? When we passed the Health Insurance Benefits Act of 1959, which became effective July 1, 1960, this was after years and years of study and deliberation. We included in that bill all active Federal employees as of that time and those who would retire in the future. We did not include those who had retired in the past, because that would have made the cost of the health insurance program excessive.

We did come back with a separate action a year later, and in a separate bill we brought in those employees retired prior to July 1, 1960. It was a great deal more costly, because they were people of the average age of 67 or 68. Obviously the cost of insurance was going to be a great deal higher. The Federal Government was not going to put any more into the program, basically, than for active employees. In fact, the entire insurance program for this group of people is inadequate. It provides only about \$15 a day for hospital benefits and a proportional amount for medical benefits. That type of program, basic and major, cost the employee \$29 for the family group plan and the Federal Government's contribution is only \$7. Therefore, it cost the former employee, who retired prior to July 1, 1960, approximately \$23 a month for something that is not adequate. He needs help in meeting the cost of his present plan as well as supplemental benefits.

There were about 400,000 retired employees at that time who were not brought under the original act, and only 235,000, or roughly 59 percent, of those actually chose to come under the system which was provided for them. This proved a defect in the program provided and therefore we felt that certainly this group did deserve some further consideration in this bill (H.R. 6675).

What were the reasons why the committee did not include the Federal employees who retired after July 1, 1960? I said a moment ago that we did enact a fairly good plan for the Federal employees in 1959. In fact we gave them a choice of 40 plans. The employee had an option of 40 plans—major medical or basic medical, a service-type plan or an indemnity-type plan. Ninety-five percent of the employees did take advantage of that, and, as I understand it, 95 percent of them actually kept the pro-

gram into the years of retirement. I also understand that the vast majority of them came under the high-option plan, which did give reasonably full coverage. In fact, there were 2.2 million employees who came under the system, with 4.5 million dependents, making a total of 6.7 million people under this voluntary health and hospitalization system, which made it really the biggest health insurance system in the world.

The committee felt, since the Federal employee had an adequate plan, which was true, that they should not be brought under this particular bill and this particular program. But what about the private industry employees who had a similar health insurance plan? If the voluntary plan for Federal employees, being a sound and reasonable one, is a reason for exclusion from this bill, then do we not actually admit that we do not need to blanket the employees in private industry who have similar systems? This actually proves the point, I feel, that many of us have been trying to make, namely, we should not have a payroll tax or any tax system for those who do not actually need health insurance benefits.

No one who has been retired prior to the enactment of this bill will have paid one quarter into this basic health insurance program being provided in this bill whether he is a former Federal employee or not. Yet the former Federal employee is the only one excluded from the bill, and to that extent I think it is unfair. Yet I have recognized, as have many Federal employees, that we do run a risk by insisting that we be brought under the plan, because we might also get trapped into the compulsory payroll deductions which will come later on.

There is another inequity which exists or which could exist in this particular proposal affecting Federal employees, which I believe can easily be corrected. Everyone will get the supplemental health insurance benefits under this bill, including Federal employees, whether they are under social security or not. Everyone can get this supplemental plan at a cost of \$3 for each individual, which will be matched dollar for dollar by the Federal Government, and that will come from the general revenues of the Treasury and not the payroll tax. It will be matched by the Government as a Federal Government and not an employer. It will not be a prepaid insurance plan where people are paying into it prior to the years of retirement and will benefit all citizens alike. Here is how the supplemental plan could be unfair to the Federal employees.

I mentioned a moment ago that we have a reasonably good plan for the Federal employees now which they can take into the years of retirement. It is not free, but it is just a reasonable, good, sound employer-employee voluntary health insurance plan. The Government actually pays one-half of the minimum basic medical cost for each employee, individual or family. In other words, the Federal Government will pay \$2.82 a month for an individual in the basic plan or \$6.76 for a family plan. As I said a moment ago, also, most employees have a supplemental plan or a

comprehensive plan which can run as high as \$35.51 a month, but the average plan and the cost of the average plan for most Federal employees runs from \$23.51 to \$23.83 a month. That is the family type comprehensive health insurance plan to which the Federal Government makes a contribution of \$6.76 or roughly 82 percent. As I say, he could carry that program into retirement.

Now let us look at the Federal employee's neighbor who might have a similar plan during his years of employment.

The CHAIRMAN. The time of the gentleman from Virginia has expired.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield the gentleman 5 additional minutes.

Mr. BROTHILL of Virginia. Now, the non-Federal employee at the time of retirement will, of course, come under the basic payroll tax plan that is contained in this bill, and if he retires prior to the enactment of the bill, he will have it free of charge and also have the supplemental plan I have been discussing at a cost of \$3 per person. He will probably have a private plan which he will be able to blend into the medicare plan and into the supplemental plan, but if the Federal employee takes the supplemental plan—and it is there for him and it is there for his neighbor as well as the Federal employee—he may find he will really be duplicating the payments for the same benefits he has under his voluntary plan. Or he would have a lot of complications in going back to the insurance carrier and saying they should recast his health plan at the age of 65, which will undoubtedly run into some actuarial problems, because the cost of health insurance at the age of 65 is a great deal greater than it is prior to that.

Here is my plan or my suggestion of how we might prevent this inequity from occurring. I am also introducing a bill to try to do this immediately. In fact, it is being prepared right now.

That is to take the Federal employee when he reaches the age of 65, and have the Federal Government as the Federal Government and not as an employer make this \$3 supplemental contribution into the voluntary health plan that the Federal employee already has and which the Federal Government already has approved of; just add that to the Government's share. This would not cost the Federal Government 1 additional penny. Since the Federal employee has his own health insurance plan, it would avoid the necessity of complicating, or changing his insurance plan or of the Federal employee having two insurance programs.

We already recognize the Federal employee as being in a different category because he is the only individual, it is the only group of individuals other than some of these subversives and aliens, not included in the basic medical provisions of the act. So we are not being inconsistent to recognize that even further and provide a separate way, another way for him to get the same benefits under the supplemental program. Why should we not make the system a little more convenient to the Federal employee at no extra cost to the Federal Government?

I have a couple more comments about the social security provisions of this bill. I know that many Members will be asked the question as I have already: why did we not increase the benefits by more than 7 percent? that the \$4 minimum is not sufficient, that we must help many people who need a great deal more money to live on. There has always been a great deal of criticism about the \$1,200 maximum that a person may earn from other sources without having his social security benefits reduced. We discussed that in the committee. In fact, the gentleman from Massachusetts [Mr. BURKE] offered an amendment to increase that limitation to \$1,500.

These are good questions that will be asked of you by your constituents and the committee is mindful of the fact that these are not overliberal increases of benefits. But there is a problem of financing the cost of these benefits. Every increase in benefits has got to be related to an increase in the payroll tax. So the committee had to weigh the problem of increasing the payroll tax, the ability of the wage earner to pay the additional money, the additional hardship that this would impose on the wage earner and the possible shock to the economy.

As has been pointed out here several times before we have caused a substantial increase in payroll taxes in this bill for these limited benefits that we have provided, including medical care benefits. Right now the total payroll tax under social security is \$348 a year on \$4,800 of income. That is for the employers and employees. But under this bill that total payroll tax will go up to \$739.20 per year on an income of \$6,600, increasing the percentage of the payroll tax up to 11.2 percent of the payroll.

Are we reaching the limit that we can afford to add to the cost of the payroll tax? How can we be sure? Some of us feel that we may already have reached the danger point when this rate does get to 11.2 percent—and it is going to get that high—whether we increase benefits later on or whether the cost of this medical care program goes up or not.

I will agree that there is going to be some increase in the payroll taxes for the social security program whether we pass the bill before us or not. It is going to go up in 1968 to \$444 per person in the total payroll. I think we can consider this as a tax increase bill because it does increase taxes as well as provide benefits.

It is not an insignificant tax increase bill either. In fact the cost of the present social security program is not insignificant. It is not insignificant even though the rate seems rather small, 3½ percent of the payroll of each employee and employer. But this year of 1965 that system will bring in \$17.2 billion in taxes and under the bill, starting next year, 1966, with these increases in this bill it will bring in a total of \$21.9 billion. In other words, a tax increase of \$4.7 billion and by 1972, this is only 7 years from now, without any action taken on the part of our committee, the total tax take under this bill will be \$33.2 billion a year or \$14 billion a year more than is being taken in right now.

The medical costs, of course, or the

cost of the medicare program are included in these figures I have given you. We are adding \$1.6 billion to the payroll tax next year for medicare, and by 1990, without any increase in costs, we will have a total intake each year of \$9 billion for the cost of medicare.

Mr. Chairman, I submit—and this has been mentioned before by a couple of the previous speakers—that this cost of medicare, this \$1.6 billion next year and which goes up to \$9 billion a year in 1990, will prevent further liberalization of these old-age, survivors, and disability benefits now and is going to prevent more liberal increases in the future.

Mr. Chairman, this is one of the major objections that we have to this plan of providing the cost through payroll taxes for this medicare program. It will place a ceiling on the cash benefits or additional cash benefits that the recipients of old-age and survivors insurance will receive in the future.

Mr. MILLS. Mr. Chairman, I yield 10 minutes to the gentleman from Oregon [Mr. ULLMAN].

(Mr. ULLMAN asked and was given permission to revise and extend his remarks.)

Mr. ULLMAN. Mr. Chairman, I want to take this occasion to commend the chairman of our committee, the gentleman from Arkansas [Mr. MILLS], for the dedicated work that he has performed with reference to this issue for the past many years, and for the masterful manner in which he has handled the committee during the writing of this most important piece of legislation.

I also would like to pay my respects to the gentleman who was in Congress before my time, the late Honorable John Dingell, who was the father of the gentleman who now occupies the chair, and who was one of the pioneers in this field and who long ago saw the need for this kind of legislation.

Mr. Chairman, I also want to pay my respects to another gentleman, Aime Forand, who is not in this House now but who was dedicated to the purposes of this bill for many years and who led the fight in this House for it. Also, I want to commend the gentleman from California [Mr. KING] who spoke earlier this afternoon for his dedicated efforts in behalf of this legislation.

Mr. Chairman, the program that we bring to you today is a uniquely American approach to this complicated and difficult problem of providing adequate medical care for our older citizens. It is America's answer to that problem. There is not prototype anywhere in the world to the kind of program we bring you here.

Mr. Chairman, this program is the assurance that we will not have socialized medicine in America, because we have over the years studied this problem and analyzed it and we have had hearing after hearing before our committee. I know of no comparable piece of legislation since I have been in Congress that has been studied more and that has received wider consideration by any committee than the legislation that we bring you here today.

The package that we have put together makes sense. It makes sense from the

point of view of the administration; it makes sense from the point of view of financing; it makes sense to the older citizens of America, and to every citizen of America from the point of view of a benefit which fills a need, a demonstrated need in our society.

Let us look at a few specifics. I can understand some confusion about this legislation because of the expensive campaign of opposition to it that has been conducted, not just in recent months, but over the course of many years. Much of this campaign has been dedicated to stirring up confusion in the minds of American citizens.

First, why do we single out the hospital benefit portion of the bill to be financed under the social security program? Was this just a willy-nilly decision, or does it have some real substantive basis?

I want to tell you it does have a real basis, and it does make sense.

What we have done is separate the institutional benefits in this bill from the physician service-type benefits. There is a real distinction between these benefits, and that distinction merits different consideration. We have said here that the institutional services that are so important in health care, basically hospital care outpatient diagnostic services, post-hospital skilled nursing home care, and home health care, are admirably adapted to the social security type of financing, the payroll type of financing that we have provided in this bill.

At the same time we have very rigidly kept out of the "basic" package, which is supported by the payroll tax, any benefits with respect to physicians' services because it is not easy to fit the latter into reasonable or precise actuarial estimates.

We have, however, in this legislation, built a voluntary supplemental package providing for payments for physicians' services. This makes sense. And I want to pay tribute to the gentleman from Wisconsin who originally proposed the legislation that took this approach to the problem. Most of us on the committee, and people generally, recognized that the need of our older citizens will not be met until you take into consideration physicians' services as well as institutional care.

What are the weaknesses of the so-called Byrnes package which will be presented to this committee in the form of a motion to recommit? It has very basic weaknesses. One of the weaknesses is this matter of a needs test. The gentleman said there was no "needs" test, but there actually is. May I say this problem of a needs test has been the greatest stumbling block in this whole area of legislation.

It was the problem which was almost insurmountable in the Kerr-Mills approach to the problem, where every State imposed a different kind of "means" test, so that you wound up with totally uneven and inadequate care for our older citizens. But the Byrnes' package provides that your individual amount of contribution depends on your status in the social security system.

I say this is inadequate and a totally unjustifiable form of a "means" test, be-

cause who is to say that because someone is receiving a minimum social security benefit he has any greater need than anyone else? What about the doctor who has enough wage earnings in his lifetime to establish a minimum social security contribution? He is going to get the maximum amount of benefit under the program at the minimum contribution.

This is only one of the weaknesses in the substitute proposal you have before you. A second weakness in this proposal is that the total governmental cost is borne by the general Treasury.

If you are going to hold down the program, hold down this cost, a far better way of doing it is to establish an actuarially sound social insurance system. That is what we do in the committee bill by establishing a fund, a separate fund, an isolated fund, and getting actuarial estimates that are accurate. You cannot afford to do otherwise. Since the social security system has been established, these actuarial estimates have been good and the estimates we have in this bill are also based on conservative assumptions. The best way to hold down a program is to tailor it to finance a particular benefit package, knowing all the time that when you put in a benefit you have to match it with the increased payroll deduction.

Mr. Chairman, on the other hand, when you take a program such as you find in the substitute proposal and finance it from the general Treasury, you have no such assurance that the cost will be limited in any manner, shape, or form. All of us know from our legislative experience that the best way to build a program is to put it on an open-ended basis, financed by the general Treasury. Then each time you get pressure for increased benefits, that pressure is going to build up on the Congress to provide those benefits irrespective of the costs.

The Byrnes' package will put a burden on the Treasury of the United States, according to the best actuarial estimates, of \$2.8 billion in the initial year. This \$2.8 billion increase in general revenues is being recommended by the very people who year after year have come before this body and have argued against increasing the ceiling on the public debt.

The committee bill we have before you is more conservative, more soundly financed by far, than the substitute proposal that is being presented.

Then I want to say that there is a third basic weakness in this substitute motion that is going to come before you. The amount of the individual contribution that the gentleman from Wisconsin would impose on our older citizens would have the effect of increasing the incentive for them to drop out of the program and cause them to fall back on the welfare rolls for their benefits in their later years. We want to accomplish exactly the opposite. We want to decrease their dependency on welfare payments. But by putting all of our older citizens under a basic hospital benefits program and financing it sensibly under a payroll tax. And then putting it along side the supplementary program for physicians' services, financed part out of the Treasury and part by the individual,

we are encouraging the maximum participation of our older citizens. With these coordinated programs we would rely to a minimum on our welfare program to carry our older citizens through their later years.

Again the "needs" test has been the stumbling block. In the committee package that we bring before you in the first two layers, we have no "needs" test whatsoever. It is the great strength of this program—you can waste all kinds of funds and all kinds of administrative effort in trying to administer a "needs" test. We do not have that test in the basic or supplementary program. In the case of the voluntary program, what we have said is this—we are going to reestablish for our older citizens the 3-percent floor on medical deductions. We are putting all the taxpayers in this regard on the same basis. We are eliminating a complication in our internal revenue structure and we are also eliminating a needs test, thus providing for a maximum of efficient operation of this total overall program.

Now there has been some talk about the long-range cost of the social security system. I am not going to go into it at any great length because it is a complicated picture. But I want to tell you this, as the Chairman has told you, that the social security system is sound and that the tables that you have in your report have been prepared by the best actuary in the business. I urge all of you to take the time to look at the study by Robert Myers, the Social Security Administration actuary, who presented to us a complete set of actuarial tables that are available to you. I hope you will take the time to examine them because he is, in my opinion, the finest actuary in the whole insurance field. Time after time after time, we had him before our committee with the best actuaries in the private insurance field, and I have never seen an instance where he has not come out on top.

What we have done in the long range estimates is to have gone up to a point in time—1971—and established a wage base ceiling of \$6,600 and have assumed that wage base will not go up any farther. When you look ahead and make actuarial estimates of what the fund is going to be in the future, you have several variables to work with. One is a wage base, the maximum amount of taxable earnings which is \$4,800 today. In this bill it will be \$5,600 next year and then we increase it to \$6,600 after 1970. Then we assume that it remains at that figure. Well, if you keep that a fixed figure, then you are going to tax rate for the hospital program which appears in the committee bill. But the sound way to finance a social insurance program in the long run is to keep that wage base increasing with the wage level over the years. I predict the Congress will do that and by doing that you will exactly be able to reduce the hospital tax rate that appears in the bill. So do not let them make a bugaboo about this 10 percent limit or 11 percent limit or any limit because it is going to be up to the Congress in the future as to how to keep this system balanced. In my opinion the fair way of doing it is to

spread the cost throughout the wage earners of this country on an equitable basis by keeping the same ratio between the wage level and the wage base that we have established in this bill now before us. I think the Congress will do it in the future and by doing it, we will hold down the tax rate that you see in the tax schedules in the report.

I want to speak for just a second about the self-employed and the separate fund. A lot has been said about the fact that this is not a separate fund. It is a separate fund and I want to point out one very distinct difference in this separate fund that involves the self-employed.

We are treating the self-employed exactly the same way as we are treating the employee under the hospital insurance program. In other words, the amount of the contribution by the self-employed will be exactly the same as that by the employee. All Members know that under the social security system, the contribution paid by the self-employed is 150 percent of that paid by the employee. So this is a very important distinction in the way that these funds will operate, and I believe it is an important principle.

One of the reasons why we established this principle of separation is because of the basic differences between this program and the social security cash benefit program as a whole.

We have heard a lot of nit picking on the part of the opposition. I wish to conclude by saying that this is a sound program. This program has been studied by the committee for many years. Last year we spent month after month after month on it. We have held public hearing after public hearing. There have been independent studies by presidential committees for years. There is no proposed legislation that has been studied more than this one.

The formula at which we have arrived at is uniquely sound. It is uniquely American. It is a milestone in legislation in this area. All of us will find, as the years go by, this is going to be considered landmark legislation, as much so as the legislation originally passed when we established the social security system.

I urge all Members to vote against the motion to recommit because it is not a sound proposal, and to vote for the committee bill, which is sound, which is creative, and which is uniquely American.

Mr. MILLS. Mr. Chairman, will the gentleman yield?

Mr. ULLMAN. I yield to the gentleman.

Mr. MILLS. The gentleman mentioned some of the points he believes are weaknesses in the suggested substitute. I wonder whether the gentleman feels that the development of any plan for the benefit of our older people must take into consideration the feasibility of compliance and the economic situation of these people in connection with it.

What I am thinking about is this: does the gentleman find any weakness in the proposed motion to recommit, in that there is no contribution to be made either on a voluntary basis or otherwise by an individual until that person is living in

retirement or on retirement income? Is it not more fair to these people to spread the cost of their hospital benefits, as we propose to do in the committee bill, over the time when they are working and before the time when they are in retirement?

Mr. ULLMAN. This certainly should be one of the points of weakness, because it is a basic weakness. What the gentleman suggests, and what we do in the bill, is much more fair, much more equitable, and will provide a much stronger program for our older citizens than trying to finance it all after the citizen gets to be 65.

I am sure, however, that if we wished to extend this business of finding weaknesses in the motion to recommit of the gentleman from Wisconsin, we could carry this on for a long time. I believe we have pointed out the basic weaknesses which exist in the motion to recommit.

Mr. JOELSON. Mr. Chairman, it is with a sense of being a participant in a great event in the social and economic history of the United States that I rise in support of H.R. 6675.

It is a humane measure whereby Americans will be able to show our concern for our senior citizens and our respect for individual dignity. Far from being a socialistic measure as its opponents charge, it will in the best American tradition provide the machinery to allow millions of Americans to help themselves.

It has been said that a civilization is to be judged by the way it treats its elderly citizens. Up until now, we have failed this test but I am thankful that at long last we are facing up to our responsibility. No society can be truly great which coldly turns its back on the plight of its aging members.

Not only is H.R. 6675 a humane measure, it is also a practical one. It will furnish a workable plan whereby the bills of our senior citizens for hospital and medical care can be met with self-respect.

We must not overlook the fact that this measure also attends to the much-needed increase in social security benefits other than hospital and medical care. In view of the cost of living, those people in retirement have experienced great difficulty in making ends meet and the bill we are considering will be helpful in this respect.

Mr. Chairman, I will have a deep sense of gratification all my life to have been a Member of the 89th Congress which is apparently about to write into law one of the great social measures of our century.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield myself 3 minutes.

I simply cannot refrain from getting into this colloquy on the matter of whether there is a prepayment by the current workers, so that they really will have paid for the benefits they will receive upon retirement. That is the implication of the statement of the chairman of the committee and of the gentleman from Oregon.

Mr. MILLS. No, I disagree with the gentleman.

Mr. BYRNES of Wisconsin. Is it not better to have people start paying during

their lifetime, rather than when they get to retirement?

Mr. MILLS. Mr. Chairman, will the gentleman yield at that point?

Mr. BYRNES of Wisconsin. If the gentleman will correct this picture, I will appreciate it very much.

Mr. MILLS. I would not want the gentleman to think I was referring to those in retirement. The gentleman remembers the committee majority part of the report clearly says that with respect to those people presently retired who would receive this benefit there is no prepayment.

Mr. BYRNES of Wisconsin. I am glad at least that we admit somebody will get the benefit tomorrow without having prepaid anything.

Mr. MILLS. I am sure the gentleman remembers that in the report. We very honestly admitted that for them there is no prepayment as such.

Mr. BYRNES of Wisconsin. At least in that area you have no alternative.

Mr. MILLS. That is right.

Mr. BYRNES of Wisconsin. Because you could not by any stretch of the imagination suggest that anybody who was getting a benefit for which they would make no additional payments of any kind had made a prepayment. However, my point here is this: if you will look at your table—and you have the table there—showing the revenues that will be produced by the payroll tax that is assessed in each year, and then you show the total you anticipate will be paid out for those hospital benefits in that year, you will find throughout that they are pretty much in balance. I will agree that there is some slight surplus that exists as far as the income to the fund is concerned, but that certainly the chairman would not contend is a funding.

Mr. MILLS. Oh, no.

Mr. BYRNES of Wisconsin. That reserve, as I understand it, is to take care of any contingencies which might occur as a result of a miscalculation of what the benefits will be or what the revenue return will be from the payroll tax. Am I correct?

Mr. MILLS. Mr. Chairman, will the gentleman yield?

Mr. BYRNES of Wisconsin. Yes. I yield to the chairman.

Mr. MILLS. I will certainly admit, just as I would admit about the OASDI Trust Funds that they will not, and they have not, operate on a funding basis; but they do operate on a prepayment basis. There is a difference between prepayment and funding.

The CHAIRMAN. The time of the gentleman from Wisconsin has again expired.

Mr. BYRNES of Wisconsin. I yield myself 1 additional minute.

Mr. MILLS. If the gentleman will yield further, if we operated the system on a funding basis, as my friend from Wisconsin knows, we would have to maintain several hundred billions of dollars in the funds.

Mr. BYRNES of Wisconsin. I must confess, Mr. Chairman, that I get considerably confused at some of the mental gymnastics going on where now we can rationalize that the hospitalization pro-

gram is not under social security and it is separate from the OASDI insurance system and now we have the mental gymnastics that you prepaid for something even thought what you are doing is simply paying a tax which is used in order to pay a benefit to someone else. That is the way the system works. To me, if I pay such a tax, I am not prepaying for any benefit that I am going to get in the future, but I am simply hoping, because I paid a tax during my lifetime for the benefit of today's retired, that tomorrow when I am retired those people who are then working and their employers will pay for the cost of my benefits. But I am not able to rationalize as to how that becomes a prepayment.

Mr. Chairman, I yield 10 minutes to the gentleman from Ohio [Mr. BETTS].

Mr. BETTS. Mr. Chairman, throughout this debate speakers on both sides have ably presented arguments for and against the bill now before us. While I want to voice briefly some of my own thoughts on the issue, I would first like to pay tribute to two friends of mine.

These two men, Amy Forand and Cecil King, with whom I have served on the Ways and Means Committee, have made a great contribution to the welfare of persons over 65. Although I disagree with the program they have advanced, they have alerted the country to the need for health care for the aged. As a result of their persistence, there has been action in many areas. Insurance companies have brought forth new plans. States have legislated to permit State 65 programs. Medical associations and hospitals have concentrated attention in the area. In Congress we have acted with new programs such as Kerr-Mills. As a result, the protection of persons over 65 against the financial drain of sickness has expanded fantastically. If no more legislation were ever passed in this field, this age group is in a much-improved position mainly because of these two men, and I think a word of commendation is due them regardless of our positions on this bill.

I also want to pay my compliments to my colleague from Ohio [Mr. Bowl]. A long time ago he saw the need of exploring the possibility of medical care with a different method of financing. He deserves much credit for keeping alive the idea of finding an alternative to the payroll tax approach, an effort which has finally resulted in the Byrnes bill.

In a measure consisting of 300 pages, naturally there are parts which are acceptable and some that are objectionable. It is for that reason that I object to so-called omnibus bills. This is true not only with H.R. 6675, but the same complaint can be directed to foreign aid bills, agriculture bills, and tax bills, to mention only a few. With only one single vote, the Member must accept proposals with which he disagrees in order to express his approval of provisions in which he is in agreement. Conversely, if he votes no to voice his objection to certain portions of the bill, he is forced to reject those provisions which he favors. This situation is especially true in this measure.

Probably the most outstanding example in this bill of a provision which has always had my support is the proposed increase in social security benefits to bring them in line with the cost of living. Last year I voted for such increases in a bill which unfortunately never became law. Benefits were thereby delayed for at least a year to persons who were justly entitled to them. I would support a bill now which dealt only with this subject. As a matter of fact, I will support it now in the motion to recommit which will be offered together with the Byrnes bill as a substitute for the compulsory payroll tax approach in part A.

Many objections have been raised to this part of the bill which is the hospital benefits provision. Among them is that it is compulsory, and therefore incompatible with the traditional free enterprise concept of the American economy. Another is that it benefits the rich as well as the poor—a feature which burdens its administration and removes it from the classification of a welfare measure. Americans have always taken care of the needy but a Government program to care for millionaires is illogical to say the least. Also impressive is the argument that the payroll tax method is retrogressive and that it creates situations where persons receive help who have not contributed to the program and where many contribute who will not be benefited.

In the Washington Post of February 11, 1965, Columnist John Chamberlain commented on this as follows:

The principle of regressive taxation that is embodied in the administration's current medicare proposal is an affront to every young couple in the lower middle income brackets. Why, in terms of their incomes, should they be called upon to pay a wildly disproportionate share of the cost of taking care of the old? Do we start the Great Society by grabbing the same amount of medical insurance money from the \$5,600-a-year kids that we take from people named Harriman, Kennedy, or Rockefeller? Why not be decent about it and pay for medicare out of the general tax funds?

But the one objection which has seemed overriding is the increasing burden on the payroll tax. In 1987 this will rise to 11.2 percent on a base of \$6,600. The Republican members of the Ways and Means Committee have stressed their concern about this in their separate views in the committee report. We say there:

We believe that the reliance on a payroll tax to finance a hospitalization program jeopardizes the cash benefit program under the social security system by imposing upon that system a liability to finance undetermined future service benefits. The magnitude of that liability should cause concern to anyone dedicated to the preservation of social security cash benefits.

A payroll tax is one of the most unfair and regressive taxes in our entire tax system. It applies to the first dollar of earnings. There are no exemptions, no deduction, no exclusions and no tax credits. No consideration is given to the taxpayer's ability to pay. The president of a large corporation pays the same tax as his worker. The justification for this type of tax rests upon the basic premise of the social security system that

the benefits, for which the tax is levied, are wage related. The financing of a hospital service benefit by a payroll tax represents a basic departure from that principle.

I simply state that I concur in these objections. They are reasons for opposing this bill. And, to further substantiate this position, I would point out that on at least two occasions, in 1962 and 1964, after weeks of exhaustive and painstaking consideration, the Ways and Means Committee rejected the concept of health and hospital care through payroll financing. These objections should not be obscured by the fact that politically attractive amendments now have been added and that the bill is labeled "Social Security Amendments of 1965." The plain fact is that the hospital insurance program in this bill, at an estimated initial cost of \$2.6 billion annually, is basically the same proposal which the Ways and Means Committee has repeatedly rejected and it is my purpose to maintain the same position which the great committee of which I am a member has consistently maintained until now.

Aside from the merits or objections to the bill, many think of its passage in political overtones. For example, the Johnson election has been interpreted as a "mandate" to pass the Health and Hospital Programs. I think this was effectively answered by an editorial in the Toledo, Ohio, Times of November 19, 1964, which said in part:

It would be a great mistake if President Johnson interprets his landslide victory as, in part, a mandate to resurrect the by now discredited medicare scheme. There were many reasons for his lopsided election, but as far as we have been able to determine medicare was never one of the issues and, for that matter, was scarcely mentioned by either candidate. One would think that medicare as a political issue or a social panacea had been effectively disposed of by the three congressional sessions in a row which refused to enact it.

As a matter of fact, the mail coming to my office on this subject is overwhelmingly against medicare—the name by which the payroll tax plan is known to the public. It is interesting to note that much of the mail is from older folks, the very people whom proponents of the bill seek to help. Most of the mail is from individuals, but groups are also represented. For example, the Eighth District of Ohio is predominantly rural and one of the most important farm organizations, The Farm Bureau, has always been against this type of financing health insurance.

In my opinion, if Congress had been left alone to work its way in the normal course of events, this bill would never be here today. But obviously the pressure of the administration and the political realignment of the Ways and Means Committee have brought this about. Until now this committee has been a bulwark which millions of people have relied on to stem the tide against oppressive increases of payroll taxes. Now that is over, and most of my constituents are fearful of the future. They understand, more than many politicians realize, that along with talk of reducing income taxes,

the bite grows bigger and bigger out of payrolls.

What will be the amendments to this bill in 2 years—or 5 years after it becomes law? Anyone who has followed Federal legislation knows the answer. There will be amendments expanding the law. And how will it be expanded? There is only one way I see, and that is by extending the payroll tax provisions to include both hospital and medical care, and thus the whole program compulsory. That was the original intention, and commonsense would conclude it is the end purpose.

Mr. GROSS. Mr. Chairman, will the gentleman yield?

Mr. BETTS. Yes, I yield to the gentleman from Iowa.

Mr. GROSS. Would the gentleman like an audience to hear him, instead of the few Members who are now present?

Mr. BETTS. I am practically completed. I would like to have just 1 further minute and I shall be finished. I do not wish to take advantage of some of the other Members who have not had audiences.

Mr. CURTIS. Mr. Chairman, will the gentleman yield?

Mr. BETTS. I yield to the gentleman from Missouri.

Mr. CURTIS. I would like to advise the gentleman from Iowa that the audience we have here is the usual attendance throughout the day. I tried to point out during debate that it is obvious this is a farce. The decision has been made and whatever the Chairman of the Committee might say and the gentleman from Ohio who is making a very fine statement might have to say, or any of us, will make little difference.

This is not a deliberative body on this important issue.

Mr. GROSS. Mr. Chairman, will the gentleman yield?

Mr. BETTS. I yield to the gentleman from Iowa.

Mr. GROSS. Does the gentleman have any estimate of how many there are on the House floor at this time?

Mr. BETTS. I would not care to make an estimate. I am not a good counter. I think the gentleman, who has been here a long time, is much better at that.

Mr. GROSS. Would the gentleman say 40 or 50, perhaps?

Mr. BETTS. I think so.

Mr. GROSS. Will the gentleman yield to me for a question or two when he completes his statement?

Mr. BETTS. Yes.

Mr. Chairman, I want to conclude my remarks by saying that I have great concern, and I call attention to the plight of the small businessman. I have never been at a hearing of this committee or any other committee, or even on the floor of the House, but what it seems the plight of the small businessman is mentioned.

As a matter of equal concern, I want to call attention to the plight of the small businessman. How can he continue to meet the employer's share of increasing social security taxes? It is a situation which is spelling doom to many of these great figures in our economy. They have been fighters in the frontlines for our free enterprise system and

I, for one, do not want to be a party to their economic extinction.

These, then, are some of the reasons why I cannot support this bill. Each Member, of course, must himself weigh the good against the bad in it. I only hope that before he casts his vote, he will give serious thought to the possible consequences of this legislation—the damage it could do to our social security system, our national economy, and to that basic right of every American—individual freedom.

Mr. GROSS. Mr. Chairman, will the gentleman yield?

Mr. BETTS. I yield to the gentleman from Iowa.

Mr. GROSS. Can the gentleman give us any idea of what this bill will cost?

Mr. BETTS. The report of the committee fixes it at about \$6 billion.

Mr. GROSS. Six billion dollars?

Mr. BETTS. That includes all four parts of the bill that the Chairman mentioned this morning.

Mr. GROSS. I thought it was \$5.5 billion, but the gentleman says it is \$6 billion?

Mr. BETTS. I am quoting the committee's report.

Mr. MILLS. That is approximately correct for the first full year. That is \$4.2 billion out of trust funds, \$1.4 billion from general funds, and about \$500 to \$600 million in contributions from individuals for the voluntary supplemental insurance.

Mr. BETTS. That includes the social security amendments?

Mr. MILLS. Yes, everything.

Mr. BETTS. In addition to hospital and medical care.

Mr. MILLS. And cash benefits.

Mr. BETTS. And cash benefits; also the increases.

Mr. GROSS. Is all this coming from taxes?

Mr. BETTS. About \$2.6 billion or \$2.8 billion comes from a payroll tax.

Mr. MILLS. Would the gentleman yield?

Mr. BETTS. I yield to the gentleman from Arkansas.

Mr. MILLS. About \$4.25 billion would come from the payroll tax supported trust fund, and \$1.366 billion would come from the General Fund of the Treasury under the committee proposal. The rest comes from persons enrolling in the supplemental plan.

Mr. GROSS. It would all have to come out of the pockets of the taxpayers?

Mr. BETTS. It has to be met by a payroll or income tax and from subscribers to the voluntary supplemental plan.

Mr. GROSS. Will the gentleman yield for me to read a brief statement?

Mr. BETTS. Yes.

Mr. GROSS. Going back to February 24, 1964, dealing with the implications of the Revenue Act of 1964, and the fiscal policy of the United States, a Member of the House of Representatives, made this statement:

In enacting this revenue bill * * * we are choosing tax reduction as the road toward a larger, more prosperous economy and we are rejecting the road of expenditure increases. We do not intend to try to go along both

roads at the same time. If we fail to limit the growth of Federal expenditures, we will be leaving the tax reduction road. Even a 1-year detour may make it extremely difficult to get back on it.

Does the gentleman recognize the author of that statement?

Mr. MILLS. Mr. Chairman, will the gentleman yield so that I can plead guilty as the author of that statement?

Mr. BETTS. I will be glad to yield to my chairman.

Mr. MILLS. I said that, and we are still trying to follow that in the committee bill. That is why I had to oppose the substitute coming from the gentleman's side, and I hope the gentleman joins me in doing it.

Mr. GROSS. Any time a bill costs \$6 billion, we are not exactly following the road to tax reduction and economy. Would the gentleman agree with that?

Mr. BETTS. I would agree that any Federal program costs money and somebody has to pay for it. This represents an increase in taxes.

Mr. GROSS. This is not the road to economy, is it?

Mr. BETTS. I do not think you can call it the road to economy, no.

Mr. GROSS. Last year, Congress reduced taxes by \$11.5 billion, and now it proposes to turn around and increase taxes by \$6 billion.

Mr. MILLS. The gentleman from Iowa, the great student of legislation that he is, is aware of the fact that this bill includes the expenditure of approximately \$6 billion but provides for an increase in taxes to offset this \$4 billion and more we are spending out of the trust fund.

The gentleman is not accusing me of being for tax reduction one year and raising taxes in another year.

Mr. GROSS. The revenue has to come from somewhere. I do not know how else I could figure the gentleman's position today as compared with his position in cutting taxes last year.

Can the gentleman give me any idea as to how many people will be put on the payroll to administer this program?

Mr. MILLS. I am not certain whether it will be in a 12- or 24-month period, but undoubtedly in assuming the initial responsibilities which are imposed upon the Social Security Administration under the bill, as I recall there would have to be somewhere in the neighborhood of 2,500 to 3,000 additional employees for the basic plan and about the same number for the supplemental plan scattered throughout the United States to carry out this program.

(Mr. BETTS asked and was given permission to revise and extend his remarks.)

Mr. HARVEY of Indiana. Mr. Chairman, I recently received a letter from Dr. Frank Green, of Rushville, Ind., a general practitioner.

The questions he raises are worthy of Members' consideration.

The letter referred to is as follows:

RUSHVILLE, IND.,
April 2, 1965.

Congressman RALPH HARVEY,
Capitol Hill, Washington, D.C.

DEAR CONGRESSMAN HARVEY: There are several conditions which will be created with the passage of H.R. 6675 that I would like to bring to your attention.

1. How and in what manner of precedence will available beds be assigned to those in need of hospital care?

2. Once an unoccupied bed in the hospital is assigned in the approved way, who will have the responsibility of dismissal?

At the present time, the average stay in our Rush County Hospital is 7 days. Under bill H.R. 6675, what is to prevent this occupancy in the hospital from going up a number of days to the limit of 60 days as provided in H.R. 6675?

It is now a fact that by only using beds the minimum number of days we are still unable to accommodate our paying needy sick. What will happen when they have it guaranteed by Government finance?

Who will have to say that the bed should be vacated when not really needed? Who will say this or that patient must get up and go home, short of the full utilization as guaranteed by law?

There cannot be a nonmedical committee in control of dismissals for here may be a very touchy area. There is no hospital committee of doctors, or hospital personnel, or management able to do this job. Only a physician who knows the patient's condition and who is willing to assume this responsibility is really able to say when a patient may be sent home against their wishes.

But reprisal or fear of reprisal is a reason why the committee idea of usage of beds cannot be depended upon. Dismissal of any patient who wants to stay might lead to a suit against the physician or hospital for abandonment or neglect.

In my opinion there is here an upset of reasonable humane and orderly procedures that will be bad for all concerned. It could destroy the present fine patient-doctor relationship.

To disrupt this fine doctor-patient relationship or use it to bail out a bad arrangement would be imprudent when it could be avoided or controlled before the contract for service is entered into and guaranteed by national law.

A contract for service between a patient and a hospital and physician should arrange for the control of overstay the time needed for the necessary care of the patient. Overuse of a bed by a patient beyond the time needed for necessary care should place this excessive cost on the patient. This would then give bargaining power to the institution to control and better use available bed space for others who need hospitalization.

Any body politic when attempting to do good must surely be aware of the obvious rebound from joy to resentment when the offered becomes impossible only because of ill-laid plans.

Sincerely,

FRANK H. GREEN, M.D.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield 5 minutes to the gentleman from Iowa [Mr. GROSS].

(Mr. GROSS asked and was given permission to revise and extend his remarks, and the remarks he previously made.)

Mr. GROSS. Mr. Chairman, I have in my hand a newspaper clipping dated-lined Washington, D.C., which says, speaking of the proposed erection of a social security building in Minneapolis, Minn., that it will cost \$722,400. Apparently preparations are already being made for this bill.

Mr. MILLS. This group of employees would not all be located in Minnesota or Washington. They would be in the gentleman's State of Iowa as well.

Mr. GROSS. That leads me to ask how many employees will be added as a result of this bill?

Mr. MILLS. Between 2,500 and 2,700 additional, I think.

Mr. GROSS. Of course, they would not all be located in Minneapolis. Continuing this news story, we are told that there will be a 20-percent increase in the social security payroll. What is the reason, and is that under the committee bill if enacted?

Mr. MILLS. It would not amount to a 20-percent increase. There are over 25,000 employees already.

Mr. GROSS. As of last February there were 34,783 persons on the payroll of the social security setup.

Mr. MILLS. I think that is right.

Mr. GROSS. A 20-percent increase would add about 7,000.

Mr. MILLS. It is my understanding it will not amount to that increase.

Mr. GROSS. I wonder where the newsmen get this information.

Mr. MILLS. I would like to know sometime where all the information that is written is produced.

I raised the question in the committee with the Social Security Administration as to what employees would be involved if we proceeded as we did. Under the committee bill, in reposing responsibility on the Social Security Administration, he told me it would be a maximum of around 2,700 employees for the basic program.

Now had we gone the other way, I would call to my friend's attention, and set up an entirely different agency to administer it, it probably would have taken 2,500 to 3,000 employees.

Mr. GROSS. I hope the gentleman has the right estimate of the increased number of employees.

Mr. MILLS. If the gentleman will yield, I do believe I may be unintentionally misleading the gentleman and, of course, I would not do that for anything.

Mr. GROSS. I yield to the gentleman.

Mr. MILLS. Let me get the facts straight. This may be nearer what the gentleman is talking about. With respect to the basic plan, anywhere between 2,500 to 3,000 employees would be needed. That is what I was talking about. I was overlooking the fact that there would be an additional administrative problem with respect to this program that we wrote in, taken from the idea of "voluntary" of our colleague, the gentleman from Wisconsin [Mr. BYRNES]. There would be additional employees involved in that and they might run anywhere from 2,500 to 3,000.

Mr. GROSS. So that would bring it pretty close to a 7,000 increase?

Mr. MILLS. It would not bring it up to quite 7,000—no.

Mr. GROSS. Well, it would not be very far from that, I will say to the gentleman.

Mr. MILLS. The point is this—if I can get the gentleman to see my point—by using the Social Security Administration, undoubtedly, we bring about the creation of fewer jobs than if we gave it to an entirely different and newly established bureaucracy.

Mr. GROSS. I have one other question since the gentleman is on his feet. How much longer do you anticipate going

on this evening in order to get the T. & T. Club, the out-on-Thursdays, back-on-Tuesday Club on the road this week?

Mr. MILLS. It is not for that purpose at all that we are here this evening. I want to get the gentleman straight on that. We are simply trying to give as many Members as possible an opportunity to speak today.

Mr. GROSS. I might say to the gentleman that there might be something going on this evening—I do not know. Perhaps there is a repeat performance at the Ebony Table.

Mr. MILLS. I am not certain of anything going on this afternoon. I have not been invited. Now if there is, I wish the gentleman would advise me.

Mr. Chairman, I yield 10 minutes to the gentleman from Massachusetts [Mr. BURKE].

(Mr. BURKE asked and was given permission to revise and extend his remarks.)

Mr. BURKE. Mr. Chairman, I take particular pleasure in supporting the provision of H.R. 6675 under which benefits will be paid to children age 18 to 22 who are in full-time school attendance. This is an especially fine and forward-looking provision. It will extend the survivorship protection of the social security program and enhance the educational opportunities we offer our young people.

A child who has lost parental support through the retirement, disability or death of his mother or father is considered dependent under the present social security program if he is under age 18 or if he has a disability which began before he reached age 18. I strongly concur in the committee's view that a child who is in full-time school attendance after reaching age 18 is similarly dependent. It is simply not realistic today to stop a child's benefits on his 18th birthday and tell him that he is now presumed to be able to go to work and to support himself. While some children can and do become economically independent by the time they are 18, most children cannot be financially independent at 18 because they have not finished high school, and they must look for a living to an economy that has little use for the untrained, unskilled, and uneducated worker. It is time we recognize that this is the situation, that this situation will continue, and that a child who has reached age 18 and is still continuing his education is as dependent on social security benefits to replace lost parental support as he was when he was younger.

Under the bill about 295,000 children age 18 to 22 would get benefits this September, when the school year begins. In a full year these benefits will add up to \$195 million. Many of these youngsters would not be able to continue their education without the benefits this bill will provide. It will mean a great deal to them and to their parents, so many of whom have written to us asking that the benefits be continued.

THE ECONOMIC IMPACT OF H.R. 6675

When we consider social security we tend to focus on its effect on people as individuals—the needs of the individual retired worker, disabled worker,

widow, and orphan—and this is as it should be. For the social security program is first and foremost a program that affects almost every American family in a very personal way and under changed circumstances—when the worker retires because of age or disability or when the family loses him in death.

But there is another side to social security. In providing an assured and regular income currently to 20 million of the most economically vulnerable people in the Nation, it provides a steady source of consumer demand that helps prevent deflation. Let us consider the bill before us today from this standpoint.

The provisions of the bill affecting cash benefit payments will become effective this year; the across-the-board benefit increase and benefits for children in school up to age 22 will be effective from the start of the year, and most of the other changes will be effective in the second month after enactment. It is estimated that these changes will increase benefit disbursements under the program by \$1.5 billion over the amount that would be paid out in 1965 under present law. In 1966, when all of the provisions of the bill affecting the cash benefits will be in operation for the full year, an estimated \$2.1 billion will be paid out in benefits over the amount that would be paid out under present law. In addition, an estimated \$1 billion will be paid out under the basic hospital insurance plan, and \$200 to \$300 million under the voluntary supplementary health insurance plan, in the last 6 months of 1966. In 1967, the first full year in which all of these benefit provisions will be in effect for a full year, an estimated \$2.4 billion will be paid out in benefits under the cash benefits program over the amount that would be paid out under present law, an estimated \$2.2 billion will be paid out under the new hospital insurance program, and \$700 million to \$1.2 billion will be paid out under the voluntary supplementary health insurance plan. All of these funds will be paid either for health care services or as income to beneficiaries, who, for the most part, will use it to meet their day-to-day living expenses. Thus the bill will not only increase the effect of the social security program as a source of assured purchasing over the long run, but will provide an immediate boost in consumer purchasing power to stimulate the economy in the next several years.

This economic stimulus will, of course, be offset to some extent by the additional social security taxes that will be collected under the bill. However, this counterbalancing effect is limited by two factors. First, the new social security tax rate schedules in the bill have been designed to avoid the excessive build-up of trust fund assets that would take place in the next several years under present law by providing for a more gradual attainment of the full rates needed to support the program over the long-range future.

In 1965 the amount paid in cash benefits will increase by an estimated \$1.5 billion without any increase in social security tax payments over the amount that would be paid under present law.

In 1966 the estimated increase in benefit payments over the amount estimated under present law, including the benefits paid under the new hospital insurance program, will be about \$3.1 billion, while the additional amount collected in social security taxes is estimated to be about \$2.2 billion. In 1967 the increase in benefit payments is estimated to be about \$4.6 billion over the amount expected under present law, while the additional amount to be collected in social security taxes is estimated to be about \$3.7 billion.

The other factor limiting the effect of the higher social security taxes in counterbalancing the economic stimulus of the increase in benefits is the fact that while the beneficiaries who would receive the additional income generally must use all of their disposable income to meet their day-to-day living expenses, the workers and employers who would pay the additional taxes use only part of their disposable income for immediate consumption. As a result, even that part of the additional benefits paid out under the bill that is offset by higher social security taxes will tend to increase consumer demand.

While our main concern in enacting this bill then, is the welfare of the millions of American families who look to the social security program for protection against dependency and want when the worker's earnings are cut off by retirement, disability, or death, a side effect of its enactment will be to strengthen the American economy. The bill will not only add to the social security program's long-range effect of providing a regular flow of consumer demand among the aged, the disabled, the widowed, and orphaned of the Nation, but will also provide an immediate stimulus to the economy that will help us sustain our economic growth in the next several years.

It is important to stress these facts, because this is not an entire drain on the Treasury of the United States. This money is going into the economy. The Government will reach back and get part of the money and keep the money in circulation, which will keep our economy going, while taking care of the needs of our aged.

Mr. MILLS. Mr. Chairman, I yield such time as he may require to the distinguished gentleman from Ohio [Mr. SECREST].

Mr. SECREST. Mr. Chairman, I believe this bill, H.R. 6675, which has replaced the old so-called medicare bill, is one of the greatest pieces of legislation to come before the Congress in this century.

I am confident that this bill, designed to benefit millions of our citizens 65 years of age and over, will also benefit doctors, hospitals, and insurance companies. In my opinion, this bill will greatly accelerate the sale of additional hospital and medical insurance just as record sales of retirement insurance followed enactment of the original social security law.

I was in Congress and supported the original social security legislation in 1935. I supported and voted in 1950 for the proposal to place independent businessmen under social security. I was a

leader in the fight in 1954 to get farmers the same benefits under social security that had for years been enjoyed by factory workers and others.

With such a longtime interest in this legislation, I am anxious that Congress do nothing that will endanger the soundness of the social security system. I want to be sure that a young man 20 years of age today will find the system as solid as the Rock of Gibraltar when he is ready to retire many years from now.

The Ways and Means Committee made a wonderful decision when it let the regular social security system alone and set up a separate tax and trust fund for the hospital insurance provided under this bill. Hospital insurance stands on its own two feet wholly apart from the regular retirement provisions of the long-existing Social Security Act. This is the way it should be. Neither program can weaken the other. Both will be sound and dependable.

Under this bill, a new title is added to the Social Security Act providing for basic hospital care to be financed by a comparatively moderate contribution by employers and employees. For persons 65 and above, 60 days of inpatient services will be provided for each spell of illness. The patient pays the first \$40 of his hospital bill.

In addition to the regular hospital service, drugs and biologicals will be provided. Under this title of the bill, private duty nurses and the first 3 pints of blood are not furnished. For each spell of illness, from 20 to 100 days of posthospital care in a nonhospital facility will be provided.

Outpatient hospital diagnostic services will be provided for a 20-day period. The patient will pay \$20 for each diagnostic study and the remainder will be paid under the basic hospital plan. After the patient returns home, the basic plan will pay for 100 visits to provide him posthospital care, home health services, including intermittent nursing care, therapy, and part-time services of a home health aid. This will include speech therapy for those whose illness results in impairment of speech. The cost of services under the basic hospital plan for people not under social security will be financed from general revenues.

In addition to hospital care, the bill establishes a voluntary supplemental plan to provide payment to physicians for services rendered in the hospital, the office, or the home. Such payments will include diagnostic X-ray and laboratory tests, electrocardiograms, basal metabolism readings, and X-ray, radium, and radioactive isotope therapy. Prescriptions are not covered but drugs furnished by the doctor are provided.

When used in the patient's home, this section of the bill will pay rental for iron lungs, oxygen tents, hospital beds, and wheelchairs. It will also provide for artificial legs, arms, eyes, and so forth. Under this plan, 80 percent of medical costs will be paid for each calendar year after payment by the patient of the first \$50 of his total yearly medical bills. The cost of this voluntary supplemental plan

will be \$3 per month for each individual who enrolls. For those under social security or railroad retirement, this amount will be deducted from his regular check. A person 65 or over will be able to deduct all medical and hospital expenses in excess of 3 percent of his gross income. This will result in limited recovery of the Government's premium contributions.

The bill provides for a 7-percent increase in all social security payments, and in every case will be sufficient to pay the individual's cost for his insurance. The Federal Government, from the general treasury, will pay an additional \$3 premium on each person who signs up for the insurance. It is expected that insurance under this voluntary plan will be furnished by Blue Cross and private insurance companies. Persons not covered by social security could make periodic payments of their half of the premium. The whole package is somewhat similar to that now provided by law for employees of the Federal Government.

In addition to furnishing hospital care and providing substantial payment toward medical bills, this legislation contains many other excellent features.

For instance, under the Kerr-Mills Act, expanded medical assistance is provided for aged persons who are indigent and help is extended to needy dependent children, blind persons, and totally and permanently disabled persons who qualify for assistance under the Act.

Each indigent old person will be judged by his own resources. The income of his children will no longer bar him from benefits. Ohio is not now under the Kerr-Mills Act, but each State is given until June 30, 1967 to qualify for this vastly expanded program which includes in-patient hospital services, out-patient hospital services, laboratory and X-ray services, skilled nursing home services, and physicians services either in a physician's office, the patient's home, or a skilled nursing home.

The whole Kerr-Mills program is vastly expanded by increasing the Federal Government's contribution by some \$200 million each year. The bill also expands the program for maternal and child health, crippled children and health care for needy children. It also includes grants for mental retardation planning.

In this bill many excellent amendments are made to the existing Social Security Act. In addition to the 7-percent increase in social security payments, the maximum family benefits under social security will be gradually raised from the present \$254 limit to \$368 effective in 1971.

Under present law, payment for children's insurance ceases at age 18. This bill raises the age to 22 providing the child is attending public or accredited schools, including a vocational school or a college, as a full-time student. The new age limit of 22 also applies to children of deceased retired or disabled workers. It is estimated that 295,000 children will benefit under this provision in 1965.

Another amendment will permit widows to receive retirement benefits at age 60 at slightly reduced rates. It is esti-

mated that 185,000 widows will take advantage of this provision in 1966.

Another excellent amendment applies to the disability program. Under present law, a worker cannot retire unless his disability is expected to result in death or to be of long, continued and indefinite duration. This new bill would make an insured worker eligible for disability benefits if he has been totally disabled throughout a continuous period of 6 calendar months. Benefits will be payable for the last month of the 6 months' waiting period and for subsequent months until recovery from the disability. It is estimated that 155,000 workers and individuals will benefit from this amendment.

Also, under present law, no worker can retire under social security without a minimum of six quarters of coverage. The new law will permit a person 72 years of age or over to qualify for social security with three quarters of coverage acquired at any time since the beginning of the program in 1937.

This bill also provides that a widow who will be 72 or over in 1966 will be eligible for social security payments if her husband died or reached the age of 65 in 1954 or earlier. This liberalization will benefit many widows.

The bill also liberalizes the social security earned income limitation. For example, a person retired under social security will be permitted to earn \$2,400 per year and lose only \$600 annually in his social security pay. This is far more liberal than the present law.

Another provision deals with divorced women. Too often a divorce will leave a wife of long standing without social security retirement. This bill will provide retirement to a divorced wife at the age of 62 if she was married to the husband at least 20 years before the date of the divorce. It also provides that a wife's benefits will not terminate when a woman and her husband are divorced if the marriage has been in effect for 20 years.

The bill has another good provision for the benefit of small farmers with relatively low incomes. If a farmer has a gross income of \$2,400 or less, he can pay his social security tax on two-thirds of his gross earnings rather than his net earnings. This will enable the small farmer to retire with a larger social security pension.

The bill also exempts self-employed members of the Amish and other religious sects from payment of social security taxes upon application and by signing a waiver of benefit rights.

Self-employed physicians and interns are brought under coverage of the social security act for the first time.

Long ago I stated that I could not support a bill that would place doctors on the Federal payroll or take from a patient the right to pick his own doctor and his own hospital. This bill in no way violates these principles. The insurance from which doctors will receive their customary fee is voluntary and the traditional practice of medicine is not interfered with in any way. This is an excellent bill, and I have attempted to discuss the major provisions in it.

We have come a long way since the days when the old and sick, who could not keep pace with the wandering tribe, were given a 3 days' supply of food and left on the trail to die. Never in the history of mankind has a generation heard so clearly and responded so magnificently to the commandment to "Honor thy father and thy mother, as the Lord thy God hath commanded thee; that thy days may be prolonged, and that it may go well with thee, in the land which the Lord thy God giveth thee."

For the older people of this Nation and many, many others this bill is a sonic boom of decency, hope, and respect. Never have I voted for any legislation with more pride and satisfaction.

Mr. MILLS. Mr. Chairman, I move that the Committee do now rise.

The motion was agreed to.

Accordingly, the Committee rose; and the Speaker having resumed the chair, Mr. DINGELL, Chairman of the Committee of the Whole House on the State of the Union, reported that that Committee having had under consideration the bill (H.R. 6675) "to provide a hospital insurance program for the aged under the Social Security Act with a supplementary health benefits program and an expanded program of medical assistance, to increase benefits under the old-age, survivors, and disability insurance system, to improve the Federal-State public assistance programs, and for other purposes," had come to no resolution thereon.

SOCIAL SECURITY AMENDMENTS OF 1965

Mr. MILLS. Mr. Speaker, I move that the House resolve itself into the Committee of the Whole House on the State of the Union for the further consideration of the bill (H.R. 6675) to provide a hospital insurance program for the aged under the Social Security Act with a supplementary health benefits program and an expanded program of medical assistance, to increase benefits under the old-age, survivors, and disability insurance system, to improve the Federal-State public assistance programs, and for other purposes.

The motion was agreed to.

IN THE COMMITTEE OF THE WHOLE

Accordingly, the House resolved itself into the Committee of the Whole House on the State of the Union for the further consideration of the bill H.R. 6675, with Mr. DINGELL in the chair.

The Clerk read the title of the bill.

The CHAIRMAN. When the Committee rose on yesterday the gentleman from Arkansas [Mr. MILLS] had 3 hours and 15 minutes remaining; the gentleman from Wisconsin [Mr. BYRNES] had 2 hours and 48 minutes remaining.

The Chair recognizes the gentleman from Arkansas [Mr. MILLS].

Mr. MILLS. Mr. Chairman, I yield 1 minute to the distinguished minority leader, the gentleman from Michigan [Mr. GERALD R. FORD].

PROGRAM FOR THE PERIOD PRIOR TO AND SUBSEQUENT TO EASTER

Mr. GERALD R. FORD. Mr. Chairman, I have asked for this time to inquire of the distinguished majority leader, the gentleman from Oklahoma [Mr. ALBERT], the schedule for the period of time prior to and subsequent to Easter.

Mr. ALBERT. Mr. Chairman, will the gentleman yield?

Mr. GERALD R. FORD. I yield to the distinguished majority leader.

Mr. ALBERT. Mr. Chairman, I am happy that the majority leader has brought this matter up, because I do want to keep the House fully informed.

Mr. Chairman, we had thought that we would have up for consideration the Department of Defense authorization bill which, of course, is a very important bill, on Wednesday following Easter. However, that bill will not be ready for consideration.

We therefore have no legislative program for the week following Easter, and it will be our plan to adjourn over 3 days at a time, within the rule, so Members can govern themselves accordingly.

Mr. GERALD R. FORD. In light of the situation in the House Committee on Armed Services with reference to the committee report on the \$15 billion-plus Department of Defense authorization bill, I fully concur with the decision of the majority leader and the Speaker in not programming or scheduling any legislation during the week following Easter.

Mr. ALBERT. Mr. Chairman, if the gentleman will yield further, we appreciate the cooperation which the minority leadership has shown in this matter. It has been very cooperative and I am happy to make this announcement to the House.

Mr. GERALD R. FORD. Would the majority leader give us an indication as to when the House will conclude its business next week?

Mr. ALBERT. The only bill we have of any consequence for consideration is the presidential succession bill, which we hope to consider on Tuesday or Wednesday. We do not have any District bills for Monday.

I cannot promise the Members that they can leave Washington at the close of business on Wednesday, but I know of no important business for Thursday of next week.

Mr. GERALD R. FORD. I thank the gentleman very much.

Mr. FULTON of Pennsylvania. Mr. Chairman, will the gentleman yield?

Mr. GERALD R. FORD. I yield to the gentleman from Pennsylvania.

Mr. FULTON of Pennsylvania. When is Pan-American Day next week? Do we have any business on that day? Usually we do not. Will there be any business scheduled after that? I understood Pan-American Day was on Wednesday of next week.

Mr. ALBERT. Wednesday of next week has been designated as Pan-American Day.

Mr. MILLS. Mr. Chairman, I yield to the distinguished gentleman from New York [Mr. KEOGH] 15 minutes.

(Mr. KEOGH asked and was given permission to revise and extend his remarks.)

Mr. KEOGH. Mr. Chairman, I should like first and immediately, even though obviously inadequately, to commend our great Speaker in his typical and gracious designation of a talented young man to act as Chairman of the Committee of the Whole. It was this young man's father with whom I had the distinct pleasure of serving in this body for almost 20 years, and on the Committee on Ways and Means for a number of years.

Mr. Chairman, you are indeed to be commended for the proud manner in which you have carried on the tradition of that great father of yours whose name will forever and closely be associated with this monumental program we are about to enact into law.

Mr. Chairman, the decisions embodied in the pending bill have been quite adequately explained in detail by those great men who have preceded me.

There are, however, Mr. Chairman, two specific provisions in the pending bill in which I have a deep and abiding interest, and I should therefore make bold to detain the committee briefly in order that the RECORD with respect to these two provisions may be clear.

As Members of the House are aware, there is a large number of our citizens who heretofore have been deprived of the protection of the Social Security Act simply because of the form in which their income is received. For many years I have pointed out that this is extremely unfair to these individuals and I have sponsored legislation to provide for their coverage. I refer, of course, to those individuals who receive their income in the form of tips and gratuities. In the 87th Congress I introduced legislation to remedy this glaring gap in social security coverage, and have consistently espoused the proposal on every available opportunity.

Therefore, it is with a sense of considerable pleasure and satisfaction that I point particularly to the provision in H.R. 6675 which will extend social security coverage to more than 1 million individuals and their families who receive their income in the form of tips

and gratuities. These individuals and their families have needed the protection which is offered through the Social Security Act for many years.

There have been two problems which had to be met. The principal difficulty has been to devise a fair and practical system for obtaining information on the amounts of tips received by an individual which could serve as a basis for contributions and benefit credits. The other problem has been the question of whether tips should be taxed as wages or self-employment income.

As is more fully pointed out in the committee report, it is a matter of common knowledge that in an occupation where employees customarily receive tips, the regular wages of these employees are generally far below those of other employees with comparable training and duties. We have received information to indicate that, on the average, about one-third of the work income of employees who receive tips in the course of employment is in the form of tips. For many, tips constitute the major source of earnings. Since the regular wages of employees who customarily receive tips are relatively low, the benefits based on those wages are likewise low. The amount of tips received by employees who regularly receive tips is estimated at more than \$1 billion a year. Under existing law, only a small fraction of this amount can now be counted. This situation will be remedied by the provision in H.R. 6675.

The Committee on Ways and Means concluded, after considering this entire problem very carefully, that the decision which it reached in connection with the legislation last year was a fair one, and that the only equitable way of counting tips toward benefits is on the basis of actual amounts of tips received and that the only practical way to get this information is to require employees to report their tips to the employer. Thus, the plan which is included in this bill, H.R. 6675, in that regard is identical to the provision which was contained in the social security bill which was passed last year, H.R. 11865.

I might also point out that the committee received full and complete information on this subject from both employers and employees before taking action in connection with this bill. Indeed, before including a similar provision in the bill last year, the committee invited written comments from employers on any technical or other problems which might be encountered in connection with such a proposal. This year, the committee heard in executive session from representatives of the employer groups most closely affected—the National Hotel and Motel Association and the National Restaurant Association representatives, in addition to the employee representatives.

Mr. Chairman, I am convinced that these provisions contained in this legislation are sound, and I again commend my colleagues for including this provision which will benefit so many individuals and their families in the years to come.

Mr. Chairman, another area with re-

gard to social security coverage which has concerned me greatly for a number of years has been the failure to permit some form of coverage of Federal employees under the program. As I have stated on numerous occasions in the past, I can perceive no valid reason why the employees of the largest employer in the United States should be precluded by law from receiving the benefits and the protection under this act. In connection with the consideration of the bill which became the Social Security Amendments of 1960, I sought for inclusion of a provision which would have afforded Federal employees an opportunity to participate in this program. I was not successful on that occasion. However, the Committee on Ways and Means agreed that efforts of the executive branch should be expedited in evolving an appropriate and sound method for coverage of Federal employees. To that end, we included a provision in the report accompanying the 1960 bill requiring the Department of Health, Education, and Welfare to submit a report to us and urging the interested departments and agencies of the executive branch to accelerate their efforts in finding a workable and sound solution to this problem and report it to the Congress at the earliest opportunity.

Mr. Chairman, I regret to advise the membership that the report which we requested in 1960 was not submitted to the committee until late in the stages of completing committee action on the pending bill. It obviously was too late for the committee to study fully the suggestions contained in the report.

The committee was advised by the Department of Health, Education, and Welfare that the executive branch has initiated an overall study of retirement provisions for Federal personnel. On the strength of this and in the face of inadequate time, the committee, reluctantly I believe, refrained from including a provision in this legislation. I do, however, invite the attention of the entire membership to the statement in this regard which is contained in pages 103 and 104 in the report of this bill, particularly the statement that it is the committee's expectation that the current study which is underway will be completed not later than December 1, 1965, and that the deadline will be met. We have delayed too long on this.

I should like to point out that the report of the Department of Health, Education, and Welfare did contain one suggestion which, although far from meeting the problem, does afford some minimum measure of solace, and I have introduced a bill to carry out that limited degree of assistance.

The gentleman from Virginia [Mr. BROYSILL] has introduced an identical bill. In effect, these bills will provide social security protection for Federal employees and their survivors who do not have protection under the civil service retirement system. This would be accomplished by providing that the period of civil service of an individual who has no right to a civil service retirement annuity, deferred or otherwise, may be

transferred to the social security system and counted as covered employment for social security purposes.

I want to make clear, Mr. Chairman, as forcefully as I can, that I do not consider the bills which we have introduced to be the total solution to this problem. It is what we regard as an absolute minimum which should be done immediately. The long-range solution involves much more than is contained in these limited bills, and I hope, when I say "long range" that we will be able to accomplish a solution to the larger problem well before the end of this Congress.

Mr. Chairman, I have pointed to these two particular areas of H.R. 6675 because they were areas of special concern to me which had not been covered in a detailed way by the speakers who preceded me. I subscribe to the comments which have been made by my chairman with regard to the monumental provisions of this bill extending medical care for the aged, in the extensions of the public assistance provisions and in the very noteworthy changes in benefits and in coverage of the old-age, survivors and disability insurance program.

Mr. Chairman, this too is a day that will live long in history. For this day is the day when the Committee of the Whole and the House of Representatives will have risen to heights unprecedented and will have taken the first long step in the direction of providing adequate medical coverage for our senior citizens.

Mr. Chairman, the Great Society is on its way.

Mr. Chairman, I yield back whatever time I have remaining.

GENERAL LEAVE TO EXTEND REMARKS

Mr. MILLS. Mr. Chairman, I ask unanimous consent that all Members desiring to discuss the bill, H.R. 6675, may be permitted to extend their remarks at this point in the Record.

The CHAIRMAN. Without objection, it is so ordered.

There was no objection.

Mr. GRABOWSKI. Mr. Chairman, I rise today to voice my support of H.R. 6675. I take particular pleasure in supporting this bill because it is my belief that this is a great event in the social and economic history of the United States.

The medicare bill, when passed, will have the greatest impact on this Nation of ours of any legislation since the original Social Security Act. It will affect a segment of our society greatly in need of help. It will contribute to the war on poverty. It will remove from many the stigma of "charity" and it will guarantee to our elderly that they will receive medical attention at the time of life when illness comes most frequently and when their financial resources are low.

As you know, I have introduced legislation identical to this bill now under consideration. I did so in the sincere belief that this is excellent legislation and that the gentleman from Arkansas, Chairman MILLS, and the House Ways and Means Committee have done a superlative job in considering all the proposals forwarded in the area of medical care for the aged and in formulating a bill which is not only workable but

which looks to the needs of the future as well as those of today.

This bill actually is divided into four parts; medical care for our elderly citizens; a part dealing with maternal and child health, crippled children and mentally retarded programs; a part revising and improving the benefits and coverage of the old-age, survivors and disability insurance program, and the part improving and expanding public assistance programs.

There has been a great deal of controversy stemming from this legislation. I know that my office, and I am sure the offices of my colleagues, reflects this controversy in the amount of mail, telegrams, phone calls, and visits from delegations which this bill has engendered. There has been every shade of opinion expressed, from complete opposition to any kind of Government assistance for the elderly to opposition to any form of social security financing to complete support for medicare under social security.

We all have had to sift these opinions and evaluate them and we have had to be guided by our own knowledge of the situation and our consciences.

When I think of some of the letters I have received, letters from old people telling of living on \$54 or \$70 a month for all the necessities of life, of insurance companies dropping health policies when elderly policyholders become ill, of hundreds of dollars in medical bills when these people cannot pay, of their shame at having to ask for welfare—which to them is nothing more than charity, then I ask how can anyone refuse to support this legislation.

This is a great bill. This is a bill which will bring innumerable benefits to a group of people which needs these benefits badly. I urge your vote for H.R. 6675.

Mr. KARTH. Mr. Chairman, as Americans we are filled with pride for our Nation's advanced technology and our great wealth. However, until very recently we have lagged behind some Western European nations in providing social services for our disadvantaged citizens.

The administrations of Presidents Kennedy and Johnson have been sensitive to our Nation's shortcomings in this area and have made great strides to overcome these deficiencies.

A national system of providing health care is an example where our country is far behind most of the advanced nations. Many of us remember when in the 1940's and early 1950's, Senators Murray and Wagner and Congressman Dingell advocated a national health program. At that time their proposal failed to get widespread support. Yet the various hearings which were held disclosed the plight of the aged sick and stirred many consciences. So while the idea of comprehensive health care lingered and vanished as a legislative issue, that of medicare for the aged persisted through the years. Vehement attacks on medicare whittled down the proposed program to such a modest "package" that even its advocates apologized for its obvious inadequacies.

Ironically, the foes of medicare unin-

tionally made H.R. 6675, as a health care bill, a far better piece of legislation. They accomplished this by educating the public, through their well-financed publicity campaign, to the shortcomings of the medicare bill.

President Johnson and Vice President HUBERT HUMPHREY last fall made a health care program for the aged a major election issue. Their overwhelmingly victory practically assured it favorable consideration by the 89th Congress.

I think it is particularly fitting that at this moment we should pay special tribute to those of our colleagues who did the pioneer work on this legislation: the late Congressman Dingell and Senators Murray and Wagner. We owe a special debt to Congressman Aime Forand and CECIL KING, Senator CLINTON ANDERSON, and others in Congress who in more recent times worked so diligently for medicare.

Much has already been written of Chairman WILBUR MILLS' unique genius in bringing out of the House Committee on Ways and Means a bill which incorporates the finest features of the different approaches to health care for the aged. He has rightly earned the thanks of the millions of people whose lives will be made better by his most influential leadership.

I will vote for the adoption of H.R. 6675 because I believe that we need to give this measure of justice and security to the aged and to the needy sick.

Mr. LANGEN. Mr. Chairman, our action on the Social Security Amendments of 1965 is going to set a pattern that the citizens of this Nation will have to live with for many years to come. We can either set an orderly pattern based on the real needs of our senior citizens or we can enact a patchwork piece of legislation that not only fails to provide all of the needed services but threatens the soundness of our social security system and paves the way for socialized medicine.

I fully realize and support the principle of adequate health facilities being made available to the aged. We have a responsibility in this field and should act. However, such aid should be made available at a reasonable cost to the taxpayers of the Nation.

This House should support a plan to assist our elder citizens in obtaining adequate health care. But we should not support a plan that saddles the wage earners of America with an increase in the regressive payroll taxes they pay. To force these wage earners to finance medical assistance for every senior citizen, regardless of whether it is needed, is unconscionable. That is why I believe we should support the substitute proposal before us, so that we will have a program that will meet the medical needs of the aged at less cost without burdening the social security system.

What is so interesting, Mr. Chairman, is that the principle of voluntary health insurance as contained in the alternate proposal is the same principle as adopted by the majority in the medical services program which was added to the administration's original medicare bill. We in the minority are, of course, pleased

that they saw fit to improve the bill to the extent of adopting a number of our proposals. However, the substitute bill before us would improve the package even more, coordinating all of the benefits under one system instead of two separate and conflicting systems.

It is difficult for me to understand the wisdom of financing some medical care through social security taxes and the rest through voluntary insurance systems. What you end up with is half of the so-called medicare bill calling for compulsory coverage paid for by the wage earners, some who cannot afford to pay for medical care for others, and the other half calling for voluntary contributions from individuals and general revenues of the Government. And even with both of the programs in effect, our older citizens would still not be sufficiently protected from the unusually high costs of extended illnesses or expensive drugs.

As we note in the minority views in the report on the bill before us, the hospitalization program proposed in this bill, as the majority now admits, was "oversold." Many of us have long contended that the medicare provisions were completely inadequate. In an effort to stave off the inevitable disillusionment, a number of Republican proposals were tacked onto the bill. I should agree that these additions were sorely needed. Now we have the opportunity of going all the way by adopting the alternate proposal with its voluntary provisions.

The alternate proposal, which I believe we should support, would meet all of the medical needs of the aged, both in and out of the hospital. It would also cover catastrophic illnesses to a greater extent than the administration bill. Under the program, all persons 65 years of age or older would be eligible on a uniform basis and their participation would be voluntary, without a means test. Our social security system would not be threatened because financing would come from general revenues of the Government and from the people themselves. Social security would only be used as a factor in determining the cost of the insurance for the individual. Insurance plans already in effect would not be disrupted. And the young wage earners of today would not be taxed for medical benefits for those who do not need it.

Mr. Chairman, it makes good sense to eliminate the duplication of coverage that is inherent in H.R. 6675 by combining all medical benefits in a single, comprehensive insurance program. We would provide greater benefits and protection for less money.

It is hoped that a majority here will cast an affirmative vote for the elderly and for the wage earners of America by supporting the alternate proposal. It is the better of the two plans. The other, as reported to us from the committee, is unacceptable because it does not provide all of the needed benefits and the method of financing seriously endangers the entire concept of social security, putting the Nation dangerously close to complete socialization of the medical profession.

Mr. PIRNIE. Mr. Chairman, the subject before us has evoked widespread interest throughout the Nation. With the possible exception of civil rights, the question of health care for the elderly has received more attention than any other program before this 89th Congress.

There appears to be unanimous consent that some form of assistance with medical expenses for our senior citizens is needed; I have found little disagreement with that basic premise.

However, as can be observed in this Chamber today, there is some disagreement respecting what may be termed the specifics of the program to be adopted. Who will be covered? What benefits will be included? How will the program be financed? Who will handle its administration?

I long have taken a position in support of a program that is soundly financed on a contributory basis during one's earning years. I believe that the individual should prepare for his retirement years, when he must anticipate medical expenses will be higher during the period of his reduced income. The simple, direct way to thus prepare is through a contributory plan operating during his working years. You might say that this is the "buy now, pay later" theory in reverse. To me, it is sound.

Further, I believe that use of the existing social security structure to collect moneys for the program has real merit because it eliminates the necessity of establishing wasteful, duplicate collection mechanisms. This proposed program is of necessity costly and far reaching; therefore, we have an obligation to put forth every effort to make it as economical and equitable as possible.

Also, I have advocated that a trust fund be established for the program, separate from the social security fund, so that Congress and the American public would have the capability of checking on the financial status of the plan at any given time in order that timely adjustments could be authorized to insure its stability.

Our obligation will not cease upon passage of this bill. We must be ever mindful of our responsibility to keep a watchful eye on the adequacy of the funds in reserve today for those who will require assistance tomorrow.

Mr. Chairman, I, like my colleagues here and millions of Americans across the country, have given much serious thought to the type of coverage that should be included in a health care for the elderly program.

I have maintained that we should endeavor to establish a basic hospital plan for all those to be covered, as well as a supplemental plan, available at a minimal additional charge to those who voluntarily elect to participate, to cover related doctor and drug expenses.

I have long expressed an interest in developing a program that would permit a partnership between the Government, the people, and private insurance companies and I trust that maximum consideration will be given to the full utilization of the capabilities of private agencies in serving this program.

One other aspect of this bill warrants particular note. In addition to coping with the health care question, it also calls for an increase in social security benefits, in essence, a cost-of-living adjustment.

In addition, it calls for the continuation of benefits to age 22 for certain children in school, provides for actuarially reduced benefits for widows at age 60 and grants benefits to certain persons currently 72 or over now ineligible. Further, it liberalizes the definition for disability insurance benefits, increases the amount an individual is permitted to earn without suffering full deductions from benefits, revises the tax schedule and increases the earnings counted for benefit and tax purposes so as to fully finance the changes made.

Many of us, during the last Congress, cast affirmative votes on a bill to increase social security benefits and to bring about several much-needed revisions in the program. We were gratified by the favorable action of the House. However, as you know, we were later disappointed when the Senate sought to include other controversial amendments which kept the measure from again coming to the floor.

Now it is a different story. We have before us a plan which incorporates sound proposals adopted from several different sources. Areas of previous disagreement have been skillfully compromised. As a result, we have a bill which is not an administration measure nor a Republican bill. It is a composite approach, far more acceptable to many of us. It is one I feel can provide desired and needed benefits for our senior citizens, present and future.

Mr. FARBERSTEIN. Mr. Chairman, this is a great day for the elderly of our country. We are finally making it possible for them to overcome their long-time fears of medical disaster by passing this legislation. We are also liberalizing the social security law in various of its facets. I am therefore proud to vote for this bill.

One-tenth of the people of our Nation are faced with the threat that ill health could, at any moment, wipe them out financially, reducing them to wards of the Nation's charities. These people are our senior citizens; those men and women who have lived fruitful and productive lives, yet who must now, for a number of reasons, hover on the brink of impending debt and despair.

Of these 18 million people, more than half have incomes of less than \$1,000 a year. A full third have no assets whatsoever besides this meager income, while half have assets of less than \$1,000. What makes limited finances such as these so frightening is that, when a husband or wife is hospitalized, aged couples today face medical bills averaging about \$800 a year. Our elderly citizens require three times as much hospital care as the young and, when they go to the hospital, they stay, on the average, twice as long. Moreover, the rapidly increasing costs of medical care hit them hardest because whatever income they do have is generally fixed.

In 1960, Congress took limited steps to meet this problem by passing the Kerr-Mills Act. This act was deficient in two respects. First of all, it mistakenly assumed that health care problems in old age are limited to the very poor. We have just seen from the previous statistics that this is not true. Even people who have lived quite comfortably throughout their working lives face the prospect of limited funds when they reach retirement. But the more pertinent fact is that the extended periods of illness that usually accompany life's later years can undermine the economic independence of even the most secure.

The second and more critical weakness of Kerr-Mills is that it leaves the application of a suitable aid program to the jurisdiction of the individual States. After 5 years, 9 States have not bothered to comply with the provisions at all, and only 7 of the remaining 41 have anything approaching an adequate program.

I am proud to say that my own State of New York has instituted one of the better programs under the Kerr-Mills, but even there it is not a complete arrangement. It necessarily uses the welfare approach and, as such, can never hope to be the ultimate answer to the real needs before us.

I, therefore, rise to voice my support for the bill which I believe does answer these needs—the proposed amendments to the Social Security Act, better known as Medicare.

This bill, as reported by the Ways and Means Committee, would give three levels of protection, each one being more comprehensive than the old Kerr-Mills Act.

First, it would provide a basic plan of hospital insurance financed through the social security system. This section would provide compulsory protection to all persons 65 and over and would be financed by equal contributions by employee and employer to a separate hospital insurance trust fund. The benefits under this section would include:

First. Hospital inpatient services—60 days for each spell of illness with \$40 deductible.

Second. Posthospital extended care—at least 20 days and maximum of 100 days following transfer from hospital, in facility having agreement with hospital.

Third. Outpatient hospital diagnostic services—available as required with \$20 deductible during a 20-day period.

Fourth. Posthospital home health services—up to 100 visits after discharge from hospital or extended care facility.

The second level of protection involves a supplementary plan covering physician's fees and other medical services. All persons over 65 would be eligible for this plan on a voluntary basis. There would be an annual deductible of \$50. Then the plan would cover 80 percent of the patient's bill for the following services:

Physicians' and surgical services in hospital, clinic, office or home; mental hospital care for 60 days in spell of illness—180-day lifetime maximum; home health services, without requirement of prior hospitalization, for up to 100 visits a year; other medical and health services in or out of medical institution including

diagnostic X-ray and laboratory tests; electrocardiograms; certain ambulance services; surgical dressings; splints, casts; rental of certain medical equipment as iron lungs, oxygen tents, braces, artificial limbs.

As a third section, the bill incorporates an extension of the Kerr-Mills program. Believing that this old plan would provide an excellent underpinning to the other programs, H.R. 6675 extends the coverage to include the blind, the disabled, and families with dependent children, and increases the Federal matching share for cash payments for those needy persons.

In addition, the bill includes a number of excellent child health programs and public welfare amendments, and provides for some much needed increases in general social security benefits.

But, while the comprehensiveness of the provisions takes steps toward securing economic stability for our elder citizens, the way in which they are applied promises to affirm a dignity for these people that previous plans have neglected. No longer must our aged be subjected to humiliating means tests. No longer must they seek protection in the form of degrading handouts. These benefits are not charity or welfare. Under this program, the individual will have contributed financially to his own security and that of his family. The benefits will be paid because the person has earned them.

Many people have been worried that such a program might lead to Government control of the medical profession. This is not the case, and in fact, the bill specifically prohibits the Federal Government from exercising "any control over the practice of medicine or the manner in which medical services are provided." Further, the bill allows the beneficiary to choose whichever doctor, hospital, or agency he desires.

It would seem to me that, rather than fettering medicine with new restrictions, this bill opens up new vistas of freedom in treatment that the profession has never known before. For no longer must a physician weigh his diagnosis in terms of what the patient can afford. He can now practice his art as it was meant to be—prescribing care solely upon what he analyzes the patient's need to be.

I am excited about this bill. I believe it to be one of the most significant pieces of social legislation to come before this Congress in years. What is more important, I know my constituency is decidedly in favor of it as well. It is for this reason that I took steps to make sure that it did not expire in committee as so many of its predecessors have. Last year, I personally had printed and circulated cards throughout by district, whereby voters could express directly their feeling for this bill. The response was great and overwhelmingly in favor of the bill. I submitted this material to the Committee on Ways and Means so that its members might be aware that the people of my district and even of the entire Nation want this bill and want it now.

For too many years in the past we have allowed important measures such this

die in the web of legislative procedure, making Congress a symbol of inaction in the face of need. Let us repudiate the "do nothing" Congresses. Let us become a "do something" branch and pass quickly this legislation which is so desperately needed and which embraces the hopes of every elderly person in our Nation.

In the above, I stated my full support for the Medicare bill. I do have one serious reservation about it, however. This concerns the omission of any provision for drug costs. In many cases, drugs can present a ruinously high cost of illness, and this is particularly true of the elderly who are chronically ill.

Certainly, many of our aged will be able to meet drug costs if they have, as I assume they will, protection of Medicare. I do not propose to subsidize all drug costs, but only those of the greatest in need.

For this reason, I plan to introduce legislation to set up a drug stamp program which will be quite similar to the very successful food stamp plan. Under this proposal, a person who is within a maximum income limitation would be issued coupons redeemable at any approved retail drugstore. Full freedom of purchase will be maintained as it has been in the food plan.

I believe this measure will plug the one remaining hole left in the bulwark we built for our elderly. I urge your consideration of it and hope to see it passed as a companion measure to the Medicare bill.

Mr. SCHMIDHAUSER. Mr. Chairman, I would like to add my voice in support of H.R. 6675. First of all, I would like to compliment Chairman MILLS and the members of the Ways and Means Committee for reporting a bill which will enable our senior citizens to receive the best possible medical attention without fear of having their lifetime savings wiped out due to a major illness, or creating a financial burden for their children. It is the solemn duty of this, the wealthiest and greatest nation on earth, to provide this program for those who have contributed so much to the building of our society when they are no longer able to participate in the labor market.

I feel that the basic plan of this bill which will provide for hospital care and posthospital care financed through the social security payroll tax is the proper answer to the problem of ever-increasing costs of hospital care that are burdening our older citizens. Also, the inclusion of a voluntary plan to provide for physicians' services, diagnostic and laboratory services, and home health services is a most fitting supplement to the basic hospitalization plan. This program, based on small monthly payments by those who choose its coverage along with a like contribution raised from the general revenues, is in the finest American tradition of free choice.

Further, this proposed bill would not only strengthen the Kerr-Mills program by establishing minimum standards for medical assistance, provide for less stringent "means test," increase the contribution of the Federal Government, but would extend coverage to all needy persons regardless of age.

I feel that we have had presented to us a bill that is financially sound. The basic plan will be administered from an actuarially sound separate trust fund, and will cost those employees who contribute to it less than 40 cents per week. The voluntary supplemental plan can be paid for by those who choose it with no loss in their present social security benefit rate.

Finally, Mr. Chairman, I feel that we owe a large debt of gratitude to Chairman MILLS and the members of the Ways and Means Committee who were able to combine the best features of several proposals into one comprehensive program of medical assistance that has few parallels in the history of legislative responsibility.

Mr. SICKLES. Mr. Chairman, one of the most pressing questions of our times—the issue of how to pay for the increased medical expenses that face many elderly Americans—will be substantially resolved by the program established by the bill to be voted on today. This bill is now on the last leg of a long legislative journey.

For a number of years, most people have recognized that our elderly citizens—who because of the miracle of modern medicine and science are enjoying longer lives—need financial assistance to protect them from the steep hospital and medical bills they frequently incur in their retirement years when their income is reduced.

To aid the elderly, Congress is considering legislation which makes a three-pronged attack on the problem.

First, and perhaps most important of all, the bill proposes a basic plan of hospital insurance protection financed primarily by an increase in payroll taxes, which will be deducted along with social security from the worker's paycheck. These funds will establish a hospitalization program available to almost every American at age 65 and over. Briefly, the program provides for: Up to 60 days of hospital care for each illness, with the first \$40 deductible; up to 20 days of posthospital nursing home care, with 2 additional days for each day that a person's hospital stay was less than 60 days; posthospital home health services for up to 100 visits, including, for example, daily visits by a nurse; outpatient hospital diagnostic services, with a \$20 deductible clause.

As a companion feature to the basic hospitalization plan, elderly Americans would be permitted to participate in a voluntary program to help them meet the cost of physicians' services. This supplementary plan would be financed by a \$3 monthly contribution by the individual participant, which would be matched by an equal contribution by the Federal Government from general tax revenues.

The program would cover 80 percent of the cost of doctors' services, home health services, hospital services in mental institutions, and other health services, after a \$50 deductible. Briefly, the program provides for: Physicians' and surgical services whether furnished in the home, hospital, clinic, or office; hospital care for 60 days in a mental hospital, with a 180-day lifetime maximum;

home health services, without prior hospitalization, for up to 100 visits, during each calendar year; additional medical and health services, whether provided in or out of a medical institution, including X-ray and laboratory tests, X-ray, radium, and radioactive isotope therapy, ambulance services, and other miscellaneous services, such as surgical dressings, casts, rental of wheelchairs, braces, and artificial limbs. Eyeglasses and dentures are not included.

In addition to the hospitalization and supplementary medical services plan, the existing Kerr-Mills program would be revised and expanded to provide care for a limited number of needy elderly persons who lack the money required to receive full health care.

The improved Kerr-Mills program would require a State to provide inpatient and outpatient hospital services, laboratory and X-ray services, skilled nursing home care, and physicians' services, in order to receive Federal grants. The States would be required to establish a flexible income test, geared to the size of the medical bill confronting the elderly person. The States will also be required to help needy elderly persons pay the various deductible costs required to participate in the supplementary voluntary program I mentioned earlier.

This three-pronged attack on the health problems of the elderly: Basic hospitalization coverage, the voluntary program for medical services, and the improved Kerr-Mills program, constitute a tremendous step forward for America.

Also included in the bill is a 7-percent, across-the-board increase in social security benefits, and many other amendments liberalizing the basic social security program.

I am giving this bill my full support because it is a major step toward the goal of providing adequate health care and financial security during retirement years for every elderly American.

Mr. ROOSEVELT. Mr. Chairman, I rise in support of H.R. 6675, the Social Security Amendments of 1965, which will provide a hospital insurance program for the aged under the Social Security Act. It also provides for an optional supplementary health benefits and medical assistance program, financed by individual premiums and Federal Government matching payments, and operated through private insurance carriers.

I have long fought for legislation to provide medical and hospital care for our senior citizens, and commend the magnificent work done in this 89th Congress by the Ways and Means Committee, and its chairman, the gentleman from Arkansas [Mr. MILLS].

Building upon the provisions of the King-Anderson bill, this bill utilizes the basic social security approach commended by both the Kennedy and Johnson administrations, which approach I thoroughly endorse.

Mr. Chairman, I have some very vivid memories, very personal memories, of the controversies that raged when the first social security bill was put forward. There were predictions of dire consequences, breakdown in the moral fab-

ric of America, and expressions indicating little faith in the American people. All of these fears have proved to be without foundation, and the social security principle has proved a sound one.

In addition, this measure provides for a program of supplementary medical care and assistance which is available to all persons age 65 or over, on an optional, voluntary basis, regardless of whether or not they are eligible for social security, railroad retirement, or other benefits.

Here we offer the American people a program consistent with both the Federal concern for the basic welfare of all Americans, and the individual and private responsibility for self and family.

There are now more than 18 million people in the country who are 65 or older, and their numbers continue to increase. Most of them have little or no financial protection against serious illness. On the average their incomes are one-half those of younger people. At the same time, their need for health care is about twice that of people under 65.

This program will make it possible for people to build insurance protection in their working years against the high cost of illness in their old age—just as they now build social security protection for themselves and their families against the loss of earnings accompanying old age, disability, or death in the family.

In addition, this far-reaching program increases by 7 percent all old age, survivors, and disability insurance benefits, with a new minimum benefit of \$44 per month.

One of the most significant provisions of the bill is that which permits payment of children's insurance benefits to the age of 22, provided the child is a fulltime student. With so much emphasis placed today on the need for higher education, this continuing assistance will be of immeasurable benefit to the children of disabled workers, as well as orphans, who could not otherwise realize their full potential by the completion of their education. Last year I introduced legislation to accomplish this worthwhile purpose, and I am particularly gratified that the Committee on Ways and Means has included it as a part of this package. It will benefit an estimated 295,000 young people.

An especially humanitarian provision of this measure is that which permits widows to begin receiving reduced benefits at age 60, if they so choose. We are well aware of the difficulties women face at this age in finding employment, if they are fortunate enough to enjoy sufficient good health to permit them to work. Some 185,000 widows who are not physically capable or otherwise qualified for full-time employment will find this aspect of the bill will greatly alleviate their plight.

Liberalized disability insurance eligibility requirements will benefit an estimated 155,000 disabled workers; while liberalized eligibility requirements for benefits will aid an estimated 355,000 persons 72 or older.

Finally, this comprehensive bill improves the Kerr-Mills program by expanding State medical assistance pro-

grams not only to the indigent aged, but also to needy persons who are part of the dependent children, blind, and permanently and totally disabled programs, increases the Federal share of payments under all State public assistance programs; and increases Federal authorization for maternal and child health services and for crippled children services.

Next week I will analyze and report in greater detail exactly what a person 65 or older can expect from this bill—how much money, how and where to obtain it, and what total benefits he can anticipate.

Mr. Chairman, we have the opportunity today to add another vital brick to the foundation of President Johnson's Great Society, and to add a significant weapon to our growing arsenal for his war against poverty.

We also have the opportunity to say to some 18 million aged Americans that the great wealth and plenty of this country, toward which their own contribution has been immeasurable, shall not bypass them, and that they shall share with younger Americans the abundance of necessary goods, the freedom from crushing worry, and the dignity of spirit afforded by our great American way of life.

Mr. GILBERT. Mr. Chairman, I have sponsored and worked for a program of medical care for our senior citizens since coming to Congress. The realization that we are about to enact this program is a source of great satisfaction to me.

The bill before us, H.R. 6675, "The Medicare and Social Security Amendments Act of 1965," represents the culmination of 13 years of surveys, studies, and very careful consideration of the health needs of an increasing elderly population, and how those needs might best be met.

I commend the chairman of the Ways and Means Committee, the gentleman from Arkansas [Mr. MILLS], and members of the committee for their outstanding accomplishment, and I congratulate the chairman for his brilliant and informative analysis of the bill on yesterday.

I rise in support of H.R. 6675, and I call upon my colleagues in the House to join me in voting prompt approval of this legislation.

No one can dispute the increase in public awareness of the health needs of the aged and the growing realization that it is our Government's responsibility to help finance a medicare program. This bill offers realistic and responsible methods of meeting a great need. I am confident it is financially sound and that it will not endanger the existing social security system. The various aspects of the proposal have been studied thoroughly on the basis of actuarial funding, financing, and administration. It presents a workable solution to the problem of financing health costs of the elderly.

The basic hospital program will be financed by employee-employer social security taxes, except for persons 65 and over who are not eligible for social security or railroad retirement benefits, whose portion will be financed from general revenues. The supplementary volun-

tary medical program provides that one-half shall be paid out of general revenue funds and the other half by premiums of those who choose to participate.

The need for the hospital and medical programs provided in H.R. 6675 is obvious. Government statistics show that the number of Americans 65 and over has more than doubled in the past 20 years—from about 9 million to 20 million. Since 1950, doctors' fees have gone up 51 percent and hospital rates have gone up 139 percent. The field of medicine leads all others in terms of increase percentages. Older people have been hurt the most by these increases. They require three times the hospital care of younger people and they stay nearly twice as long when hospitalized—and yet the income of older couples is less than a third of that of younger couples. As age increases, so do chronic illnesses; 8 percent of all citizens 65 and over suffer some kind of chronic ailment. Nine out of ten elderly are hospitalized at least once during their retirement years. The inability of millions of elderly people to purchase costly private policies has been brought out in committee hearings and revealed in Government surveys. Almost one-half of the elderly now receiving social security benefits have less than \$12.50 a month in retirement income outside of their social security checks. They either cannot afford private insurance programs or they are considered too poor a risk.

Mail from my constituents has been overwhelmingly in favor of medical care under the social security program. Hundreds of letters have described pathetic circumstances of bare existence on small social security and other pensions as the only source of income. I have been reminded over and over of the tragedy of these older citizens, already barely able to afford the necessities of life, amidst spiraling rents and other living costs. A serious or prolonged illness could leave them, as it often does, in a state of complete destitution and fright.

The program of medical care provided in H.R. 6675 will help these senior citizens maintain their dignity and independence; it will provide them economic security and will eliminate the necessity of charity.

Mr. Chairman, I want to mention the main benefits of this program. The basic hospital plan, available to all 65 and over—an estimated 20 million—provides: Hospital care up to 60 days for each spell of illness, with the patient paying the first \$40; posthospital extended care of at least 20 days and a maximum of 100 days following transfer from the hospital to a hospital-affiliated nursing home; outpatient diagnostic services, with the patient paying the first \$20—credited to the hospital in-patient deductible of \$40 if hospitalized within 20 days; and up to 100 posthospital home visits by a nurse, therapist, or health aide. This part of the program provides for hospital care, nursing home, diagnostic services and home-health care; it does not pay for doctor's services, for drugs outside the hospital, or for eyeglasses, false teeth, hearing aids, and artificial limbs.

The voluntary supplementary medical plan covers doctor's fees and other medical services. All persons age 65 and over will be eligible on a voluntary basis. Those who choose to enroll will pay a monthly premium of \$3, and an equal amount will be paid by the Government out of general revenue funds. If a person is receiving social security benefits, the \$3 premium will be deducted from his social security check. After an annual deductible of \$50, the insurance would pay 80 percent of the cost of the following services: Doctor and surgical services in a hospital, clinic or home; up to 100 home service visits a year without the requirement of prior hospitalization contained in the basic hospital plan; X-ray and lab tests, electrocardiograms, radium therapy, rental of equipment such as wheelchairs, oxygen tents, iron lungs, braces and artificial limbs, and certain ambulance services; and hospital care in a mental hospital and limited payment for treatment of mental conditions outside a hospital.

Mr. Chairman, I have strongly supported the 7-percent increase in social security benefits which H.R. 6675 provides, retroactive to January 1, 1965. Too many of our 20 million now receiving social security benefits—the aged, disabled, widows, and orphaned children; who are the most economically disadvantaged in our country—have only their small social security checks as a major source of income.

I am pleased also that the bill contains other provisions I have long supported and worked for—to continue social security benefits for a child up to age 22, if he is attending school. I never felt these benefits should stop at age 18, when a child is in school and is in the most expensive years of his life.

Another feature of the bill which I sponsored in a separate bill and I am pleased was included is that tips received by employees shall be considered as part of wages for social security purposes. Many employees work in industries where a large portion of their income is in the form of tips, and while they have had to count these tips as wages in paying income taxes, they have not been included as part of the wages on which social security benefits are computed.

Other important provisions in H.R. 6675 are: Persons eligible for social security payments whose outside earnings are between \$1,700 and \$2,400 will receive less of a reduction in their benefits. While this is an improvement, I would have preferred the inclusion of my own proposal to remove altogether the limitation on the amount of outside income. Widows will have the option of receiving benefits at age 60 instead of 62, with the amount actuarially reduced to take into account the longer period over which the benefits will be paid.

Mr. Chairman, H.R. 6675, the Medicare and Social Security Amendments Act of 1965, is a far-reaching and important bill which will improve the economic security of every American family. It is not a perfect bill, but it will solve most of the health problems of those who can least afford medical and hospital care. This legislation will free

persons 65 and over from the threatened burden of vast medical expenses; it will provide protection that will permit our elderly citizens to live out their lives in dignity instead of in constant dread of imposing financial burden on their children or the necessity of turning to welfare agencies.

No one in this Congress could be more pleased than I am that, after so long a time, we are about to fulfill the promises made to our senior citizens to give them a program of medicare.

Mr. ZABLOCKI. Mr. Chairman, at the outset I want to commend the House Ways and Means Committee and its illustrious chairman, Mr. MILLS, for reporting to the House of Representatives the Medicare and Social Security Amendments of 1965.

This comprehensive, far-reaching measure is a tribute to the Congress and our American system. It proves anew that our Government can act effectively to meet the needs of our people. As an original cosponsor of the medicare measure proposed by our former colleague, the gentleman from Rhode Island, Aime Forand, and a sponsor and supporter of the King-Anderson proposals, I am most gratified that the House of Representatives will at last have the opportunity to express the national consensus on health care for the aged.

I have no doubt about the outcome, for two reasons. First, the need for new legislation to meet the health needs of our elderly citizens long has been recognized. Second, the bill we have before us today provides a practical and prudent remedy to the problem of medical care for the aged.

By combining a hospital and nursing home care program under social security with a voluntary supplementary plan providing doctors' and other medical fees financed by individual contributions and Federal matching funds, and with improvements in the Kerr-Mills Act, the legislation before us today mounts a three-pronged attack on the health problems of our aged.

It will also assist our senior citizens by increasing basic social security benefits by 7 percent, thereby helping them cope with increasing living costs and strengthening their purchasing power.

Mr. Chairman, today in my own State of Wisconsin, there are some 440,000 individuals who are over 65 years of age, according to the U.S. Census Bureau. By 1970 the State will have 482,000 elder citizens. Over 10.5 percent of the State's population is in the 65-plus age category, as compared to an average of 9 percent for the rest of the United States.

At present, if a financially disastrous illness strikes a Wisconsin senior citizen, he or she has only two choices. One is to go "on the county" with all the demoralizing and degrading connotations of that term. The other is to apply for aid through the State's Kerr-Mills program.

Although Wisconsin is reputed to have one of the better Kerr-Mills plans in the country, it still has fallen far short of need. For example, the State is able to provide only 45 days of hospital and nursing home care, in contrast to the

120 days recommended by the Department of Health, Education, and Welfare.

Our State, like many others, is hard-pressed to raise sufficient revenues to finance many necessary and expensive State programs. For that reason, although the enabling legislation envisioned a \$5 million biennial appropriation, the State budget provided only \$2,842,500 for the first 2 years of the program.

Adding in the Federal matching contribution, and figuring the program as established in Wisconsin on an annual, per capita basis, it divides out to \$7.15 per elder citizen in the State.

This is one-fifth the average expense of a single day in a hospital, when one includes room, board, nursing care, and medical supplies.

Of course, because of income and other restrictions, many of the State's elder citizens have not been eligible for Kerr-Mills assistance. An estimated 180,000 are eligible, however. For them the annual per capita share is about \$16.60 per year. That is \$6 less than the average daily rate for a semiprivate room in a Milwaukee hospital.

From these figures it is evident that, while it has helped ease the problem, the Kerr-Mills program in Wisconsin has been only a stopgap measure. It has not provided the answer to the pressing medical problems that plague the elder years of so many of our citizens.

Facts and statistics, no matter how impressive, can never convey the feelings of misery and hopelessness that have accompanied old age for so many of our citizens.

To gain an appreciation of the plight of the aged, one must listen to the personal experiences of our senior citizens. Many persons have written to me on this problem, citing cases which they knew intimately. Because of the compelling nature of these letters, I would like to quote brief excerpts from a few.

From a Milwaukee man:

I believe that my wife's father would still be alive today if we had medical care under social security. He was too proud to ask for help when he needed it.

From a West Allis, Wis., man:

My father had a stroke and my mother had a gall bladder operation which was covered by the insurance they carried. Then came the time to renew their hospital insurance. My father sent the check in well before it was due but the insurance company claimed they never received it. The company said they could renew their policy at a very substantial increase in rates which my parents could not afford. Now they are at a time in their lives when they need protection most and they don't have it. It is time for the Government to act to protect these people.

From a retired Milwaukee man and wife:

My wife and I cannot seek medical care on the small pension checks we receive, which we need so badly now. Please vote for the medicare bill.

From a West Allis man about his mother-in-law:

She could not afford hospital and surgical insurance so all of her savings were spent. My wife's sisters and brothers borrowed money also to help and their resources were used up. In addition, some had sons and

daughters in college and this made it very difficult. This is a real problem in the United States. We are far behind most industrialized countries in furnishing medical care.

From an elderly man in Palmyra, Wis.:

My wife and I have to live on \$109.50 a month with no other income. If you think it is easy to get along on that just try it once for about 2 months * * *. Total hospital and doctor bills amounted to \$1,600.48 for 2 years. I had to sell my home in order to pay for it.

From a Milwaukee retired worker:

I have retired * * * due to a heart condition on doctor's orders. Due to this condition, it is quite hard to get coverage for my protection. The requirement and premium asked for by the insurance company that I contacted was impossible for me to get protection in my case. My pension check will not cover the amount asked for by the insurance company for my wife and myself. When you pass 70 years of age, it gets to be a problem to get by.

From a Milwaukee man:

Being one of your constituents, I would like you to know that I am a little tired of waiting for action on the medical bill for the aged * * *. Too many lives are at stake.

From a South Side elder citizen:

Had a heart attack in the year 1962. Was protected by a policy I had taken out in 1955. Unfortunately, had no surgery clause. It was necessary to operate on my leg on account of a clot that formed there while lying in the hospital. Was in the hospital 40 days. My protection was only for 31 days. The hospital bill was \$2,040.15. I paid \$973.75. In addition, I paid approximately \$900 in doctor and surgeon bills for which I was not protected.

Mr. Chairman, by enacting the program embodied in the Medicare and Social Security Amendments of 1965, the Congress will provide benefits to every man and woman in this country who is over 65. For the first time many Americans will know security in old age. Banished will be nagging worries that illness might force them to lose all they have gained during years of labor and that they will be relegated into a life of poverty.

The opportunity to act against this evil in our society has been long in coming. After years of a hard-fought campaign, victory is in sight. We must not fail now to exercise our clear-cut responsibility in acting favorably on the meritorious and historic measure before us today.

Mr. Chairman, I trust the recommittal motion will be defeated and that the bill as reported by the Committee on Ways and Means will receive the overwhelming approval of this august body.

Mr. FUQUA. Mr. Chairman, we all recognize that many of our elder citizens have difficulty in meeting their medical bills. I am not insensitive to this fact. Some method must be found to assist those who are in need of medical assistance and cannot afford the care that they need. But let me emphasize how strongly I feel should be considered the word and the fact—need.

For some 20 years now some form of compulsory Federal health care under social security has been presented to the Congress. Today we are to vote on a bill which is supposed to meet that problem, and a bill which has many sections

of merit. But, Mr. Chairman, in my humble judgment this is not the bill that should be passed by this Congress.

This bill would cover only a segment of our population, not our entire elderly population and without regard to their needs. Benefits would accrue to all those so covered, regardless of whether they have need for such benefits or not. The cost would be tremendous. I am informed that this bill would impose on the workers today a staggering sum of \$35 billion for hospitalization benefits for those already over age 65.

I am well aware of the needs of the people in my particular district in regard to this legislation which I think might well be somewhat typical of other parts of the Nation. I know full well of the dire need of many of our citizens. I also know full well that many, many of those who would be covered under this program have no real need for such coverage.

Its cost would be shifted to the working man today. Those paying the bill are not prepaying for future benefits for themselves; they are paying a payroll tax for benefits for those who would immediately be covered.

It matters not whether the recipient of this program has adequate hospitalization insurance or whose bills might be rather mild and that he would have no problem meeting them. This is not considered.

For when you lump those who have a real and earnest need in with those who have no such need, you have a situation where a tremendous burden is placed upon the back of the American taxpayer.

I have stated consistently that while we have a need, while there is a dire need on the part of so many, the solution to this problem should be based on need.

This bill does not follow that concept. In my opinion it does not take into consideration the fact that hundreds of thousands who will be covered and receive benefits have no real need for those benefits. By the same token, many thousands who have a real and dire need and who are not covered by social security are left to the mercy of the world. I simply cannot believe that this is the proper approach to the solution of this problem.

Mr. Chairman, I think further that the American taxpayer should not be deluded into thinking he is getting something for nothing. At the outset of this program, the tax will be only a fraction of what it must ultimately become to make the program financially successful.

The bill we are now debating provides for a mandatory hospitalization program financed by a payroll or social security tax, together with a voluntary program for medical services financed partially by contributions and partially out of the general revenues of the Treasury. And still it does not attack the problem on the basis of the needs of the individual American citizen.

Illness does not strike just those who are covered by social security. Those in need who are not covered are left almost in an unfortunate position as they are today. A truly good program would have

been to attack this problem on this one basis—to provide care for those who who cannot afford to pay.

The benefits would be obvious. Allowing those who could afford to pay their own medical bills to do so, when multiplied by the thousands upon thousands of such individuals, would cut the cost to a portion of what it is today.

I think of two individual cases of the past year involving constituents of mine. One involved a father who had brain surgery, remained in a coma for over a month and then passed away. The medical bills were staggering in this case. The cost of such specialized surgery and equipment is beyond the means of most families to pay. A program that would have helped in this case is justified.

But there was another father of about equal age who entered the hospital with a rather minor ailment for a week. After treatment, he was returned to health and released, paid a hospital bill of less than \$200, which he could afford, and has not had a health problem since. He did not need a program; he was fully able and willing to pay his own way. I can see no justifiable reason why the working man should be shouldered with an additional tax to help pay costs for a case such as the latter.

This bill provides for 60 days of hospital care and related benefits for the aged irrespective of financial need, without any financial contributions from those already over age 65, and without regard to whether the individual may already be adequately protected against such costs.

This does not take into account the results of catastrophic illnesses. A long and serious illness might easily run beyond this point of limited days, and again I emphasize, this program does not have its basis in meeting the real need of such cases of prolonged and serious illness.

Further, this bill automatically extends these benefits to all of those presently over age 65, and to those who attain that age before 1968, without regard to coverage under the social security system, except that the bill excludes certain Federal civil service employees and their families, irrespective of age.

Anyone reaching age 65 after 1967 must have the specified quarters of coverage under the social security system to be eligible for hospital benefits. It thus excludes all those in need who attain the age of 65 without the required quarters of social security coverage. It excludes those Federal civil service employees I have mentioned. It does not meet their need, which might be just as acute as that of any of those covered by its provisions.

If experience is any basis, we can reasonably expect that the tax rate in the bill will not be adequate to meet the financial demands of the program. Our experience is that the tax rate will be increased and that the wage base will be "updated" and expanded to provide additional funds to meet the increases in the cost of service.

And all the while, Mr. Chairman,

there will be thousands of American citizens in dire need of medical assistance, who will not be covered and assisted. At this same time, there will be hundreds of thousands who will be receiving benefits who have no real need for them and would willingly forgo them in return for a program that was based on need, at a much less cost and burden to the American taxpayer.

I have studied and restudied this bill and all of its provisions. I sincerely believe that while it has its merits, while there are provisions which I can support and would like to support, there are major provisions that I feel are not in the best interest of the American people. I am deeply concerned that it does not meet the needs that it was originally designed for—the aged who cannot afford the high cost of medical care.

I sincerely urge that the House not pass this bill in its present form and that it will send it back to the committee for further study and evaluation, in an effort that we might come forth with a program which has its basis in need, and would truly serve our elderly who cannot afford adequate medical attention.

Mr. O'BRIEN. Mr. Chairman, this is a historic day in the legislative history of the House of Representatives. At long last, we are demonstrating that our great Nation has the will and the way of meeting the health problems of our elderly people without stripping them of their dignity.

While this bill covers the full spectrum of the aged, I am particularly elated over what it will do for a vast army of middle income and small business people, who labor all their lives to insure a decent standard in their declining years.

These are the people who, through their taxes, have shouldered such a heavy share of our humane programs.

Too often, I and our colleagues have witnessed the impact of a grave and costly illness upon these people in their old age.

Where have they been able to turn? I know the gates of public welfare are there, but the key to them has been too costly for these people. Strip yourselves of dignity and the fruits of your past diligence, we tell them, and we will patch your aged bodies without cost.

Now, under this bill, these people can march into the golden twilight years with heads high. No longer will they be forced to choose between death and poverty. They will be insured, not only against the costs of ravaging illness, but against the loss of all the fruits of their diligence.

I am proud to support this bill and I am proud of my country for the support a majority of its citizens have and are giving this humane bridge to a better tomorrow.

Mr. RODINO. Mr. Chairman, I rise today in support of one of the greatest measures which has ever been before Congress in my time. Every year for many years now, the question of medical care for the aged has been pressing upon us, until it has grown and swelled into the comprehensive bill before us today.

And I believe that this measure is inevitable. There is room for argument on what the results of the bill may be, but there can be little argument over the necessity of this legislation. Some kind of medical care bill is inevitable and it is my contention that the bill before us today offers the best possible solution to the problems it seeks to confront.

I believe the moral character of a nation can be accurately judged by the way it treats its elderly.

It is to America's credit that this country has recognized, met and eased many of the special needs and unique problems that beset our aged citizens after their years of fruitful labor are ended and they enter that strange new era of sharply curtailed income known as retirement.

The social security program, established 30 years ago in the darkness and despair of the great depression, has provided a basis for financial independence for millions of senior citizens.

Through the years, Congress has authorized a succession of increases in the monthly payments under social security to compensate for the inexorable rise in living costs that strikes so cruelly at those who struggle to make ends meet on a fixed budget. Increased benefits notwithstanding, Congress has seen to it that the social security program remains actuarially sound.

Many other measures have been enacted by Congress to enhance the economic and social well-being of our Nation's elderly, including tax relief, a senior citizens' housing program and expanded social welfare services.

The biggest single unmet need—and many of us have been emphasizing it for years—is in the area of medical care. Just as a disease untreated becomes a plague, so the neglected medical problem has increased in complexity and urgency.

Those who argue that the bill before us is contrary to the traditions of this country, the tradition of self-help and independence; those who argue that this measure or one like it is no more inevitable than the downfall of private medicine that will surely follow; remind me of an image evoked by Sydney Smith, the English parson, in writing about the need for electoral reform in 19th century England: "In the midst of this sublime and terrible storm, Dame Partington was seen at the door of her house with mop and patters, trundling her mop, squeezing out the sea water and vigorously pushing away the Atlantic Ocean."

This comparison of the House of Lords' attempt to stop reform to that of Mrs. Partington against the ocean may be applied equally well to the situation in which we find ourselves today. I believe the Medicare bill is a necessity in terms of needs, in terms of our ideals, in terms of our traditions. This legislation is the logical step in the evolution of our welfare programs that has progressed since the Social Security Act became law in 1935.

The bill is not, as its detractors claim, a radical proposal, but is simply just the next step in providing services and finances to select groups of those who are in need.

The medical care portion of the bill, part I, amends the Social Security Act by adding two new titles—XVIII and XIX—to the Social Security Act. It establishes three new programs for health insurance and medical care for the aged. The first of these creates a basic plan providing protection against the costs of hospital and related care; the second authorizes a voluntary supplementary plan providing physicians' services and other medical and health services to cover certain areas not included in the basic plan; the third expands the Kerr-Mills medical care program for the needy and medically-needy and combines all the vendor medical provisions for the aged, blind, disabled, and families of dependent children, now in five titles of the Social Security Act, under a uniform program in a single new title. This expanded medical assistance program is estimated to provide new or increased medical assistance to about a million needy persons during an early year of operation.

Let me pause for a moment to examine just why these programs are necessary in terms of need, in terms of our traditions, and in terms of our ideals.

The number of elderly individuals receiving old-age assistance under the Social Security Act for November, 1964 was 2,161,464, with an additional 217,336 receiving medical assistance for the aged. In my State of New Jersey alone, in November there were 13,872 individuals receiving old age assistance with payments averaging \$81.25, \$18.87 of which went as vendor payments for medical care, an average which is considerably larger than that of the country as a whole. In November in New Jersey there were 5,287 individuals receiving medical assistance for the aged, the average payment in this instance being \$250.27, again a figure that is considerably larger than the average of the Nation as a whole.

What do these figures mean? The average payment to a recipient of old-age assistance is so low as to mean that there are a significant number of our elderly who cannot afford medical care adequate to the needs of their age. Let me quote at this time from the report of the Committee on Ways and Means:

Today, few older people are free of the fear that costly illness will exhaust their savings. In many instances the one or more episodes of hospitalization which virtually all aged people will experience can quickly dissipate whatever savings they have been able to accumulate for their later years. The frequent medical attention required by older people suffering from chronic illness can also be a serious drain on their financial resources. A large and growing proportion of the elderly applying for public assistance have had to do so only because they cannot afford needed health care. Frequently the assistance for which they must apply is very limited in scope and inadequate to meet their needs.

Mr. Chairman, the fear of major illness hangs like a sword of Damocles over the heads of our senior citizens. One strike is sufficient to wipe out a lifetime of savings at a time of life when it is impossible to replace. When that modest, hard-earned nest egg is gone, everything is gone. Those carefully nourished dollars are the difference between a ful-

filling existence and a drab retirement. Without the nest egg, hope gives way to despair and the glowing sunset years become chill, dark and empty. There are too many of our elderly who must regard death as did the poet Shakespeare as "Just death, kind empire of men's miseries." There are too many of our elderly we feel, as did King Henry VI, that "Having nothing, nothing can they lose."

Too many of our older citizens continue to exist in the threatening shadows of poverty and financial ruin, through no fault of their own. They have been trapped by the ever-rising cost of illness that has soared high above their ability to pay. The dollar that was set aside, often at considerable sacrifice, some 10 or 20 years ago, buys only a fraction of a dollar's worth of medical care at today's prices.

This is not as it should be in a country that prides itself on its prosperity and on the concern it has for its citizens. This is not as it should be in a country that wishes its people to have freedom from want, from fear and from hunger. For the elderly in this country today do not have that freedom. The bill before us seeks to give them at least freedom from the fear of the cost of sickness so that they may use their income to equip themselves against the pangs of hunger and of want.

I have heard in the controversy that has accompanied this legislation that the bill is not justified by experience. I do not think that this is true; but if it were true, nations are sometimes compelled to act without experience for their guide, and to trust to their own wisdom for the anticipation of consequences. The instances where this country has been thus compelled to act have been eminently successful to date. Where were the precedents for the midnight ride of Paul Revere, or the legislation of the New Deal which helped to get this country back on its feet after a paralyzing depression? To those events, contrary to experience and unsanctioned by precedent, we owe the structure of this country today.

Extolling the past at the expense of the present is a sign of old age, and this is not a nation of old men. But it must be a nation that gives to its elderly the option of equipping themselves with an easily affordable insurance plan to provide for the payment of doctors' and other specialists' services. At the very least, it must be a nation that gives to its citizens the vehicle by which they can contribute during their working lives to the fund out of which their health expenses will be paid when they no longer are strong enough to earn the money with which to pay those expenses.

The medicare provisions of this bill are but a continuation of the old-age insurance system that was initiated with the Social Security Act. They provide for the financing of payments through a separate payroll tax and separate trust fund. It has been estimated that approximately 17 million insured individuals—who are presently eligible for social security benefits—and 2 million uninsured would qualify for benefits on July 1, 1966. The cost of providing basic hospital and related benefits to people who are not social security or railroad retire-

ment beneficiaries would be met from general revenues. There will be no problems in obtaining the revenues with which to finance these new programs.

The voluntary plan with premiums of \$3 are to be paid by social security beneficiaries by deductions from their benefits—which, by the way, will be increased a minimum of \$4 per month for all beneficiaries so that all who so desire may participate—and matched equally by Federal revenue contributions. Moreover, the provision in the income tax law which limits medical expense deductions to amounts in excess of 3 percent of adjusted gross income, as well as the present limitation on medicine and drugs for persons under 65 are abolished. Provision is thus made for partial or full recovery of Government contribution from enrolled persons with incomes high enough to require them to pay income taxes.

During the almost 2 months of deliberation over this measure I have heard much criticism of the architects of the bill. Now that it is before us, we realize the injustice this does to its authors. Men cannot sit down and draw up a plan as complex as this with as much ease and as much exactness, and with as complete gratification of their wills, as an architect can do in building or altering a house. The works of legislators are not the works of calm wisdom—they are not the best that a dreamer of dreams can imagine. It is enough if they are the best plans which the times in which they act will permit.

This bill does fit the needs of the moment. It is tailored to meet the needs of our elderly through its medical care provisions, the increase in the benefit and coverage provisions and the revision of the financing structure of the Federal old-age, survivors, and disability system, and in the expansion of existing public assistance programs.

Mr. Chairman, I would like to mention briefly these additional features of the bill. Old age benefits are increased by 7 percent across the board, with a \$4 minimum increase for a worker retired at 65, an increase I have long supported. I have been a strong advocate, too, of reducing the retirement age at which eligibility begins, to 60, as I am delighted to see the provision which provides actuarially reduced benefits for widows at age 60. I am delighted also to see the continuing benefits up to age 22 for certain children in school, the liberalization of the definition and waiting period for disability insurance benefits, and the increase in the amount an individual is permitted to earn without suffering deduction from benefits. The tax schedule and the earnings base are revised to finance the changes made.

The public assistance programs are expanded by: increasing the Federal matching share for cash payments in State programs for the needy aged, blind, disabled, and families with dependent children; eliminating limitations on Federal participation in public assistance to aged individuals in tuberculosis and mental disease hospitals under certain conditions; and affording the States broader latitude in disregarding certain

earnings in determining need for aged recipients of public assistance. It is estimated that some 7.2 million persons will be eligible for increased cash payments under the Federal-State matching programs.

Finally, this bill contains a provision aimed at helping another needy segment of our population. This provision increases the amount authorized for maternal and child health and crippled children's services over current authorizations of \$40 million in 1966 by \$5 million for fiscal 1966 and \$10 million in each succeeding fiscal year to reach \$60 million in 1970 and after. In addition, it authorizes \$5 million for fiscal 1967, and up to \$17.5 million for each succeeding year, for grants to institutions of higher learning for training professional personnel for health and related care for crippled children, particularly mentally retarded children and those with multiple handicaps. A new provision is added authorizing a 5-year program of special project grants to provide comprehensive health care and services for children of school age or preschool children, particularly in areas with concentrations of low-income families. And last, there is a provision providing grants of \$2,750,000 for fiscal year 1966-67 to assist the States to implement and followup plans and other steps to combat mental retardation authorized under section 1701 of the Social Security Act.

Mr. Chairman, I do not want it said of the 89th Congress that we were afraid of change for the sake of change. I have said before that there can be little argument over the necessity of legislation of this sort. And it is heartening that even those groups and individuals who were most outspokenly opposed to medical care for the elderly have come at last to recognize that the problem can no longer be ignored.

I honestly believe that this is the best bill to meet our needs today. The bill and the problems it seeks to confront do fit so exactly that we can say they were made for each other. There will be mistakes at first as there are in all changes, but reasonable men who know what to expect will find that a very great good has been obtained.

It has been said of this country that it is exempted, by its very newness as a nation, from many of the evils of the old governments of Europe. It has no mischievous remains of feudal institutions, and no violations of political economy sanctioned by time, and older than the age of reason.

The Social Security Act is not sacrosanct. It has been amended and improved in the past, so let us improve and amend it today. Let us remove the ominous specter of major illness, and most of our elderly will find they can enjoy their autumn years in relative comfort and with new peace of mind, secure in the knowledge they will not live out their lives as demeaned charity cases beholden to Government doles.

I am certain that this bill will lengthen and strengthen the warm glow of the sunset years for all of our older citizens—today, tomorrow, and for generations to come. I urge its swift, unanimous approval.

Mr. Chairman, to borrow again a phrase from Shakespeare, "Let us make this the certain glory of an April day."

Mr. O'NEILL of Massachusetts. Mr. Chairman, a generation ago the United States established a system of contributory social insurance providing protection against the loss of earnings due to retirement in old age. This social security program has been broadened and improved so that today it covers practically all kinds of employment. It provides protection for families of retired workers as well as for the worker himself, for survivors of deceased workers, and for totally disabled workers and their dependents. The program has been adjusted from time to time to improve the protection provided, thus responding to social and economic changes in our society.

However, an examination of the adequacy of social insurance protection for the aged clearly shows that the existing programs providing cash benefits are not enough to meet another pressing problem faced by today's aged—the problem of unpredictable costs of health care and low incomes with which to meet these costs. I am convinced that the bill before us for consideration would meet this problem; its major thrust is to enable people to contribute from earnings during their working years for protection against hospital and related costs after age 65 when their income is generally curtailed. In addition, the bill would provide for a voluntary supplementary plan—financed out of monthly premiums from beneficiaries with matching amounts from Federal general revenues—for protection against the cost of physicians' services and a variety of other health costs. And the bill before us would make important improvements in the existing social security program and in the Federal-State public assistance programs.

NEED FOR PROTECTION

The financial resources of older people are extremely limited. They have, on the average, only half as much income as younger people, and they have little in the way of assets that could be used to supplement this income. One-fourth of aged families, and one-half of the aged living alone, are at or below the poverty level. This situation is not likely to improve substantially. The increasing frequency of early retirement plus a longer life span will mean more years over which retirement resources will need to be used.

While their incomes are low, total health expenditures of people past 65 are very high—twice as high as those of younger people. In the case of hospital expenses, the ratio is almost three to one. Thus, older people have a special problem arising from the cost of health services—they need more care and they have less money to pay for it. This need is aggravated by the fact that health costs are rising and will undoubtedly continue to rise. As a result, many aged people have been crippled financially by high health costs and have had to rely on their children for help, obtain medical care through private charity, ap-

ply for public assistance or go without adequate attention.

Although the problem of financing health costs of younger people is being met to a large extent by private insurance organizations, most of the aged cannot purchase effective health insurance protection at a price they can afford to pay. Despite years of effort and hard work by voluntary insurance organizations, only a little over half of the elderly have any kind of health insurance coverage and most of what they do have is very limited. The basic difficulty has been that the cost of private insurance is necessarily high because the aged need so much in the way of health care. They are unable to pay the cost of premiums for adequate insurance from low retirement incomes and can ordinarily obtain health insurance only on the expensive individual, nongroup basis. As a result, most voluntary health insurance within reach of the pocketbooks of the aged is very inadequate, covering perhaps 20 percent of their medical costs.

And public assistance programs cannot and should not be relied upon to meet the problem of high health costs and low incomes of the aged. Because of financial priorities, some States have not developed medical assistance programs, and other States are forced to severely restrict the help that can be given. Public assistance by its very nature can only benefit the very needy—there must be a requirement that the person demonstrate he can no longer get along on his own. This "means test" often involves investigation of the aged individual's personal affairs, and those of his family. Many aged people would rather forgo needed medical care, even to the detriment of their health, rather than ask for charity. These are serious deficiencies in public assistance but the most serious deficiency is that public assistance does nothing to preserve the financial security of the great bulk of the aged who are able to get along unless or until serious and costly illness occurs; public assistance does nothing to remove this threat to independence and self-support.

It is clear then that public assistance programs and private health insurance cannot, by themselves, meet the problem created by the combined effect of high health costs and low income in the aged. The problem requires an approach that does not depend on payment of the entire cost of protection after retirement but instead enables individuals to pay for protection against the major cost of illness in old age over the course of their working lifetimes. The method of contributory social insurance, which underlies the present social security program, offers the only practical way of making sure that almost everyone will have hospital protection in their old age. This bill provides this essential part of the answer to the problem.

PROVISIONS OF THE BILL

I would like now to comment briefly on the two health insurance programs for persons over age 65, which would be provided for in this bill. The basic plan

will provide protection against the costs of inpatient hospital care, and related services which can frequently take the place of inpatient hospital care, for 19 million older people. Over 99 percent of the aged would receive protection under the basic plan. In addition to the inpatient hospital care, the basic plan would cover posthospital extended care, organized home health services and outpatient hospital diagnostic services. Coverage of these important alternatives to inpatient hospital care would help subordinate financial considerations to medical considerations in decisions on whether inpatient hospital care or some other form of care would be best for the patient.

The basic hospital insurance plan will be financed by a special, earmarked earnings tax paid by employers and by workers during the years while they earn and are best off.

Mr. Chairman, in addition to the basic plan, this bill offers a supplementary plan for people who are age 65 and over. Individuals who voluntarily enroll in this program would receive protection against the cost of physicians' services and other medical and health services in and out of medical institutions. This program would be financed through small monthly premiums paid by participants and matched by a Federal Government general revenue contribution.

Mr. Chairman, I congratulate the members of the Committee on Ways and Means from this side of the aisle who have presented us this fine bill. And I express my great admiration for the leadership of the great chairman of that committee, my esteemed colleague from the State of Arkansas, who exercised statesmanship of the highest order in constructing a bill which can have very wide support. I can assure the Members of this body that, in the words of our President, "a tremendous step forward for all of our senior citizens" will have been taken when we pass this great piece of legislation.

Mr. BOLAND. Mr. Chairman, when President Franklin D. Roosevelt signed the Social Security Act of 1935, on August 14 of that year, he described it as a "cornerstone" upon which a great system for the protection of the American people would be built. That August day exactly 30 years ago marked a momentous change in our way of life. To my mind it sets the point at which we recognized that we had matured as a Nation. For then, for the first time in our country's history the Federal Government recognized that meeting its responsibility for promoting the general welfare in a rapidly industrializing society called for this new kind of protection. As Mr. Justice Cardozo said, in delivering an opinion of the Supreme Court on the social insurance programs, we had come to the place in our country's history where "needs that were narrow or parochial a century ago may be interwoven in our day with the well-being of the Nation." He continued:

What is critical or urgent changes with the times. The problem of preventing want in old age is plainly national in area and dimensions.

Thursday, April 8, 1965 will, I believe, go down as another great day in American history for it will be recorded that the House of Representatives on that day adopted one of the greatest social security bills since the original act. For upon the cornerstone built on behalf of the well-being of the American people 30 years ago is being erected the structure of a great social security system—one which will provide true protection against want in old age, and one which is "plainly national in area and dimensions."

The Social Security Amendments of 1965 face up to the growing need of older people for protection against the mounting costs of the fine medical care available in this country today. As the able report of the Committee on Ways and Means points out:

Today, few older people are free of the fear that costly illness will exhaust their savings. In many instances the one or more episodes of hospitalization which virtually all aged people will experience can quickly dissipate whatever savings they have been able to accumulate in their later years. The frequent medical attention required by older people suffering from chronic illness can also be a serious drain on their financial resources.

A large and growing proportion of the elderly applying for public assistance have had to do so only because they cannot afford needed health care. Frequently the assistance for which they must apply is very limited in scope and inadequate to meet their needs.

The bill before us today meets this problem in a number of ways. First, it establishes three new programs for health insurance and medical care for the aged under the Social Security Act by setting up first, a basic hospital insurance plan providing protection against the costs of hospital, related post-hospital care—skilled nursing home and home health visits—and outpatient diagnostic services for individuals 65 or older, financed largely through the social security method; second, a voluntary "supplementary" plan providing physicians' and other medical and health services financed through monthly premiums of \$3, matched equally by Federal Government revenue contributions; and third, an expanded Kerr-Mills medical care program for the needy and medically needy which would combine all the vendor medical provisions for the aged, blind, disabled, and families with dependent children, now in five titles of the Social Security Act, under a uniform program in a single new title, with the Federal matching share also being increased.

To improve the health services available to our young people as well, the bill would, among other provisions, greatly strengthen existing programs for maternal and child health and crippled children's services and establish a new 5-year program of special project grants to provide comprehensive health care and services for children of school age or preschool children, particularly in areas with concentrations of low-income families.

I am also pleased to see that the cash benefits program is strengthened in a

number of ways. The 7-percent increase across the board—the first since 1958—is not only a greatly needed liberalization but it will also make it possible for many people to purchase the \$3 a month supplementary plan. The liberalization of the earnings limitation is another adjustment to modern times which will be welcomed by many people. Finally, I was particularly pleased that the committee added the provision adopted last year, but lost when the bill died in conference, which would continue benefits to dependent and surviving children beyond age 18 and up to age 22. For, as the committee report states:

A child who cannot look to a father for support (because the father has died, is disabled, or has retired) is at a disadvantage in completing his education as compared with a child who can look to his father for support.

Mr. Chairman, the Committee on Ways and Means is certainly to be congratulated for the careful but comprehensive consideration and wisdom they have shown on all parts of the bill they reported to this body. It is, indeed, a great bill, and a historic bill. It meets the challenge of our President as to our obligation for advancing the Nation's health in a way which, I believe, calls for bipartisan support. For, as the President said in his health message:

The health of our people is, inescapably, the foundation for fulfillment of all our aspirations.

And it recognizes that—
what is critical or urgent changes with the times.

Mr. EDWARDS of Alabama. Mr. Chairman, I rise in opposition to the portion of this bill which would impose a compulsory payroll tax in order to finance a system of hospital benefits. I support most of the other provisions in this bill.

The disadvantages of the compulsory payroll tax in financing a program of hospital benefits are so substantial as to outweigh the advantages in other parts of the bill, and therefore, it is my intention to support the Republican motion to recommit, and to oppose the committee's bill.

Every American, regardless of his religious beliefs, should have an opportunity to make his own decision regarding participation in a Government program of hospital insurance. First, this program assumes that all citizens over 65 have similar needs for hospitalization help. In actuality, though the need of some is beyond question, many others have neither a need nor a desire for outside help in paying for their costs of illness. Second, many Americans feel deeply about their own self-reliance, and would reject the imposition of Government programs. They are determined to take care of themselves and of their families. And I submit this is a character trait we should encourage, not discourage.

In addition, this is an inefficient way of providing help where it is needed. The taxes paid by younger workers under this bill will not be commensurate with the benefits received by those over 65. We need to formulate programs with greater efficiency.

I also want to indicate that this bill imposes a liability of approximately \$35 billion on the social security system, or on all employed persons presently paying social security taxes. This endangers the strength of the system itself, and raises the question as to just what upper limit we in the Congress think taxpayers will tolerate in payments into the system in order to keep it solvent.

The bill provides only modest increases in the payroll tax in the early stages of the program. But sharp increases come later. This is another example of political scheming, and is like telling the country: "Yes, we are fiscally irresponsible, but we in Congress have enabled the country to delay the day of reckoning. The big bills will come later."

The bill is also not entirely fair to taxpayers, because a payroll tax is a regressive tax. It hits the lower and middle income people the hardest. No consideration is given to an individual's ability to pay.

I support several provisions of the bill. It is gratifying, for example, that after years of delay, the need is now recognized for liberalization of the earning test for the aged who seek to supplement their social security benefits with outside earnings of their own. My bill, H.R. 5236, on this issue is only one of many, and action on this point is long overdue.

I also support the 7-percent increase in cash benefits, the provision for lowering the eligibility age from 62 to 60 for widows, and the amendments to the Kerr-Mills program.

The Republican proposal is for a national health insurance fund financed partly through voluntary participation and partly through general revenues. This program provides comprehensive care, and would not seem to promise more to needy people than it can produce.

It is completely voluntary, it preserves the role of the States in providing individual assistance, and its cost would be more in line with actual benefits received.

I want to emphasize that persons over 65 who need financial help should have it. I regret that those of us who oppose a compulsory payroll tax are pictured as somehow being against senior citizens. I oppose the compulsory payroll tax not because I am against senior citizens but precisely because I want to see the Government do the most effective job possible for them.

The compulsory payroll tax will not do the job. It will bind us all more closely to the rigid structure of Government direction without providing the most effective help possible.

We need a voluntary program with financing assistance from general revenues, and I am hopeful that we can achieve it.

Mrs. SULLIVAN. Mr. Chairman, the House of Representatives is taking a great and historic step forward in the passage of the most important social security bill since the original act was written into law in the first administration of Franklin D. Roosevelt—the 1935 act which was condemned and attacked in the 1936 election as a "tax on payrolls" and as a disaster for American labor and American business. The original act, of course, was no disaster—it

was one of the firmest foundations ever constructed for our continuing prosperity and economic stability.

I am proud to support this bill as reported by the Committee on Ways and Means. It is far better, in the coverage it contains and the financial hazards it helps our older citizens to guard against, than we had dared to hope for just a few months ago. For the bill now not only contains a prepayment hospitalization insurance program such as called for in the King-Anderson bill, but also includes the essential features of a voluntary health insurance program for the retired such as we have had for some years for retired Government employees. The bill, furthermore, authorizes a very substantial broadening of the Kerr-Mills program which we passed in 1960, but which some States, like Missouri, I am sorry to say, have never implemented. I hope Missouri will finally put the Kerr-Mills program into effect.

Furthermore, the cash benefits of retired workers and their dependents, and of the widows and dependent children of workers who have died, will all be increased by this legislation now before us.

MISINFORMATION ABOUT THE LEGISLATION

Mr. Chairman, I have been deeply concerned over the misinformation which was spread so wildly about the possible effects of this legislation. Quite a number of older people now living on small social security annuities have written me in fear and distress that adoption of a prepayment hospitalization insurance program for the retired, and of a voluntary health insurance program such as this bill also authorizes, would bankrupt the social security fund and jeopardize their monthly cash benefits.

One poor woman wrote to me:

I do not want to take the risk of having my \$87 a month cut off because the fund is broke from paying the hospital expenses of wealthy people who don't need any help.

Others voiced similar fears. Of course, the hospitalization insurance program will be financed under a completely separate fund—just as is the social security disability program—so that the monthly annuities received by retired workers or by survivors of workers could not be adversely affected in any way, no matter what might happen to the special hospitalization insurance fund. A special payroll tax will be levied just to cover hospitalization insurance. All money received from that special tax will go into a separate fund just to cover insured hospitalization expenditures. The main social security fund, covering old age and survivors insurance, will not be subject to any withdrawals for hospitalization or health insurance or disability insurance or for the Kerr-Mills program or any separate and distinct social security programs.

OPPOSITION IS BASED ON WRONG PREMISES

I can understand, if not agree with, the fears expressed by many of the doctors that because the Federal Government is going to help pay part of the hospitalization costs of elderly people covered by social security, that in some way the Federal Government will insist upon telling the individual doctor what treat-

ment to provide, or which patients to send to the hospital for operations. No such thing can happen under this legislation. The Federal Government administers a health insurance program for millions of active and retired Federal employees, but does not tell any doctor what to prescribe, or what to charge, or how to treat any patient, or what patient he may or may not send to the hospital for an operation.

Thirty years or so ago when the Blue Cross program was being started, the American Medical Association, as I recall, was extremely critical and unhappy about this idea, too. The same fears were expressed, only that time it was that a hospital administrator—rather than a Federal bureaucrat—would attempt to tell the physician how to prescribe, or what to provide in the way of treatment, or which patients to send to surgery. Since then, the medical societies have learned the value of the prepayment insurance idea, and the Blue Shield program is a good example of how this lesson was put to use.

The voluntary health insurance program set up under the social security bill now before the House of Representatives will make it possible for all of our elderly citizens to obtain insurance—for which they will pay a monthly premium—to assist in the payment of medical bills. The advertising campaign in behalf of the AMA's so-called eldercare bill as a substitute for the King-Anderson bill, stressed the limitations in the King-Anderson bill, which did not provide any assistance in paying doctors' bills and other medical expenses. Now the social security bill has been amended to cover a portion of such costs. So anyone who opposed the King-Anderson bill on the ground that it did not go far enough to help the elderly meet the high costs of medical care should be able now, in good conscience, to support this new bill which meets this problem directly.

DOCTORS AND THEIR FAMILIES TO BE INCLUDED
UNDER SOCIAL SECURITY

The opposition of the American Medical Association over the years to anything and everything about social security has had the consequence of keeping all self-employed physicians out of the social security system. They are the only professional people, or self-employed people, not now covered. Their spokesmen maintained that doctors as a group never retired—that they worked right on through their later years—and thus would never benefit to any large extent from the social security retirement program.

What the spokesmen for the profession failed to point out, or apparently to consider, was that many young physicians die each year from heart attacks, overwork, or other causes before they can establish any real financial security for their families, and their widows and children—alone among all groups of Americans—received no survivorship benefits under social security. I know personally of a number of cases of this nature, where the widow has faced a real struggle. This bill ends this discrimination, which has been self-imposed by the medical professional against

the families of young practitioners who die leaving widows with small children. I am glad to see this discrimination ended, just as I was when we made the same change some years ago for dentists, lawyers, and all other self-employed workers and professionals except physicians.

REPRESENTATIVE WILBUR MILLS ACCOMPLISHES
ONE OF THE GREATEST ACHIEVEMENTS IN CON-
GRESSIONAL HISTORY

Mr. Chairman, I want to express my deep personal gratitude to Chairman WILBUR MILLS, of the House Committee on Ways and Means, and to all of the Democratic members of that great committee, for unanimously joining in reporting this outstanding social security bill. Mr. MILLS has accomplished one of the greatest achievements in the history of the House of Representatives, in winning the combined support of all of the liberal and conservative Democrats on the Ways and Means Committee for a bill which takes a giant step forward in social security coverage. The Mills bill is, as I said, the most important social security bill since the original act was passed just 30 years ago. Of all of the legislation those of us in the Congress today have been privileged to vote for during our congressional careers, this social security bill we are now passing will be one of those measures we will always look back upon with the greatest pride for the part we have been given the opportunity to play in the legislation's passage.

Every bill we pass is touched with great importance to some Americans. This one represents a most vital matter—vital in the literal sense of longer, healthier lives—for every American. I salute Chairman MILLS for guiding it to committee approval and House passage, and I salute President Johnson for giving this greatly expanded bill his official support, even though it goes far beyond his original recommendations. This is a proud moment for each of us voting "yea" on this bill.

Mr. GILLIGAN. Mr. Chairman, I rise in support of H.R. 6675, and I want to congratulate the chairman and members of the Committee on Ways and Means for their very fine work in this most difficult task.

This is a good bill, well designed in every respect to meet the urgent needs of this country's elderly citizens for adequate health care. For too long has this need been unfulfilled because of partisan conflicts and entanglements. Now is the time for all of us on both sides of the aisle to join in passing this bill without a dissenting voice. This bill will pass—about that I have no doubt. The larger the margin of approval, the better it will be for everyone in this Chamber and throughout the country.

Mr. Chairman, I have read this bill carefully and the hearings with close attention, and I have listened closely to the debate. I have searched the corners of my mind for possible unwarranted assumptions and have found none. I have examined each section of the bill and found nothing objectionable. I have heard nothing in this debate to arouse any doubt about the necessity and wisdom of this bill.

I will vote against the motion to recommit and vote for the bill on final passage, and I ask that whoever is inclined to do otherwise carefully re-examine his intentions if they spring from party considerations.

Mr. WOLFF. Mr. Chairman, at an earlier date, I spoke before this august body on the medicare bill. At that time, I set forth the pressing need for a medical program to give security to our senior citizens. This need is still with us.

Before the House, we have a new and better medical security proposal. This plan now offers comprehensive coverage. It meets all objections to the previous proposal; in short, it is a superlative piece of legislation. Those sections of the original medicare bill, the eldercare bill, and other proposals which had merit have been combined into one legislative work. Not only have all objections that may have been raised to the medicare bill been abrogated, but we now have a bill that has additional strength through incorporating the good points of these alternative plans.

This is a bill which meets the needs of our country head on. This is a bill that can satiate our demands for medical security. I have worked hard for, and in fact cosponsored, the medicare legislation for this Congress. It is indeed gratifying to see the fruition of this work, this excellent bill, before this House.

The American people must bear the fruit of this proposal; we must pass this bill.

Mr. COHELAN. Mr. Chairman, I rise in support of this farsighted and long-needed bill to provide adequate yet reasonable health care protection for our Nation's older citizens.

The dimensions of the problem which necessitate this bill are familiar, but a few facts are worth repeating, worth emphasizing, and worth remembering.

People over 65 have a far greater need for hospital and medical care than their younger neighbors. They use hospitals nearly three times as much and their health costs are fully twice as high.

But this increased requirement comes at a time when these older Americans are least able to afford it. It comes when the costs of health insurance are highest and when their incomes, on the average, and in the great majority of cases, are the lowest.

Almost half of those 65 and over and living alone receive less than \$1,000 a year, and three-fourths receive less than \$2,000 a year.

Only half have any health insurance at all and only a handful—perhaps 1 in 20—have protection against as much as 40 percent of their health costs.

The discoveries of medical science have been exciting. The increase in life expectancy—from 49 to 70 years of age in the last 65 years—has been remarkable. But it is not enough for a great society to add new years to life. We must also add new security, new protection, and new meaning to that life.

Mr. Chairman, from the extensive mail I have received on this subject and from the opinion polls I have sent to my constituents, I am firmly convinced that most Americans do not want this prob-

lem met by more lenient welfare programs. What they want, and what the need, is an insurance system under which all workers can pay, during their productive years, for protection against the hospital and medical costs which they will increasingly meet in their later years.

This bill meets that test, and it does more. But it does not remove individual responsibility. Rather it increases it, and this is as it should be.

I am particularly pleased, Mr. Chairman, that the Committee on Ways and Means has added a voluntary, supplemental plan to the basic protection against hospital and nursing home care. By covering payments for physicians and related costs through small monthly premiums, a great area of need, otherwise all too often neglected, is being met.

I am also pleased that the committee has provided for a 7-percent increase in social security cash payments. Not only is this increase long overdue, but the minimum increase of \$4 per month will insure that no worker will be excluded by reason of cost from the supplemental plan.

There are provisions of this bill I would change. For example, I am opposed to the deductible which must be paid for hospital and medical care. I am in complete sympathy with its purpose but the fact remains that some who are in need will be excluded and no one should be subjected to the humiliation and degradation of a means test.

But on balance, Mr. Chairman, this is a good bill. It is an essential, fair, and reasonable bill. It is a bill we have discussed a decade now and more and it should be passed with strong support as a constructive response to a pressing national problem.

Mr. WILLIAM D. FORD. Mr. Chairman, it is indeed a proud moment in my life, to be recognized by my dear friend and fellow Michigan Congressman, JOHN DINGELL. We of Michigan are all proud that our colleagues in the U.S. House of Representatives have chosen you to be the presiding officer of this great legislative body during the entire debate on the medicare bill during the past 2 days.

During our campaign for Congress in the fall of 1964, you and I shared many speaking platforms from which we promised the people of our districts that we would support President Johnson's program of adequate medical care for senior citizens as an extension of benefits under the Social Security Act.

We are, Chairman DINGELL, extremely fortunate to be here at this moment, with you in the Speaker's chair, and me on the floor of Congress, working together for the passage of this law. I believe that this Congress will accept the mandate of the people who voted in November 1964 and will pass this legislation. We cannot only report back to Michigan, the faithful keeping of our promise to support this legislation, but the fact of our success and the reality of the adoption of the greatest piece of legislation to come before the Congress in many, many years.

We, who represent Michigan are also extremely proud in the knowledge that our own MARTHA GRIFFITHS, of the 17th

District of Michigan, as an influential member of the Ways and Means Committee, was one of the chief architects of H.R. 6675 as we find it before the House of Representatives today.

I want to offer my wholehearted and enthusiastic support for H.R. 6675, the Medicare and Social Security Amendments of 1965. I firmly believe that this action is long overdue, and that we have too long ignored the health care needs of America's older citizens. The need for improving amendments to the Social Security Act contained in this bill is equally urgent.

The most serious threat to the security and peace of mind of our senior citizens is the high cost of illness and medical care. Statistics show that 8 out of every 10 persons aged 65 or older have some type of serious illness. They require hospital care more often than younger persons, and they must stay for longer periods of time. And yet, nearly half of America's retirees have no form of health insurance.

Scientific advances have and are adding years to man's lifespan. In the United States today are more than 18 million persons who have passed the age of 65, and their ranks are increased each year by another 1,500,000. By 1975, we shall have more than 33 million over 65. Unfortunately, this is the most neglected segment of our society. I consider it a national disgrace that our Nation has delayed so long in making adequate health-care provisions for our senior citizens.

Thirty years ago, we established a social security system to provide some measure of financial independence for retirees. But we have done virtually nothing to free them from the fear of becoming a financial burden on their children due to illness.

These millions of Americans contributed from their paychecks for many years to help assure themselves of independence and security with dignity in their old age. I think that they are entitled to this as a matter of right, not as a matter of welfare or benevolence.

Our senior citizens, Mr. Chairman, are a valuable and important segment of our population. Let us not forget that the benefits we enjoy today are the results of their work and dedication in past years.

As President Johnson has so aptly stated, "compassion and reason dictate that this logical extension of our proven social security system will supply the prudent, feasible, and dignified way to free the aged from the fear of financial hardship in the event of illness."

Mr. Chairman, I urge the immediate passage of H.R. 6675.

Mr. BARRETT. Mr. Chairman, I am wholeheartedly in favor of H.R. 6675, the Social Security Amendments of 1965, now before the House for consideration. It has been many years since the first plan to provide health insurance for the elderly was introduced, and it is indeed a great moment to finally have this bill scheduled for debate and a vote. We have the opportunity to go down in history as a Congress which has made manifest the Nation's concern for its elder citizens.

This bill is so comprehensive that in the brief time allotted to me I will concentrate on the health insurance provisions, which will help more than 17 million older Americans.

Other parts of the bill also make important and necessary improvements in our whole pattern of social legislation.

The bill extends the benefits of the Kerr-Mills program to other groups in the population who are as disadvantaged as the elderly—the blind, the disabled, children who cannot be adequately supported by their parents—and who would not be able to provide necessary medical care for themselves.

This bill also authorizes increases in expenditures for the maternal and child health and crippled children programs who are designed to help mothers, and handicapped children in need. A new provision is added to the Social Security Act which will authorize special health care to unfortunate young children, who need this help in order to do adequate schoolwork and to lead a normal life.

The Social Security Amendments of 1965 will help our elderly citizens in many ways since it authorizes improvements in the basic social security system as well as begins a new program of health insurance. The basic hospital insurance plan will give protection to Americans over 65 against the costs of hospital, related post hospital care—skilled nursing home and home health visits—and out-patient diagnostic services. These benefits would be financed through a separate payroll tax and a separate trust fund. Those senior citizens who are not eligible for social security benefits would be covered out of general revenue.

This basic plan, which would lighten the dark cloud of financial worry that hovers over the elderly, would be supplemented by a voluntary plan providing physicians' and other medical and health services financed through monthly premiums of \$3 by individuals matched equally by Federal Government revenue contributions. Most of our older Americans would join this plan. They would be able to do so because of the 7 percent across-the-board increase in social security benefits, which would more than cover the cost of premiums.

I do not call this proposed legislation revolutionary. It is a natural development, given the comparatively low financial position of the elderly and their lack of resources to cover medical expenses. Americans over 65 are more likely to have serious illnesses, and need hospital care, than are any other age group; and they are least able to pay either out of savings or through private health insurance, which is too expensive for their limited budgets.

Today too many senior citizens are denied even all the necessities of life because of the burden of illness and the fear of dependence. We in Congress have the opportunity, and the duty, to make the life of these older Americans a more pleasant one, to allow them to enjoy their later years in the peace and comfort which we all hope will surround our own years of retirement.

Mr. MICHEL. Mr. Chairman, I find myself in a very difficult situation today, for this bill, H.R. 6675, entitled "The So-

cial Security Act Amendments of 1965," embodies what has been paraphrased as "the best of bills and the worst of bills."

It includes such excellent provisions as a badly needed and long overdue increase in social security benefits, the establishment of a more realistic minimum benefit for those whose participation in the system before reaching the age of 65 had been, through no fault of their own, minimal.

I would point out again that these benefits should have been made available to social security recipients almost a year ago if the administration had not seen fit to deliberately doom the enabling legislation by attaching their now discredited original medicare bill to it.

Quite frankly, Mr. Chairman, I like the provision in this measure that would continue benefits to age 22 for children attending school.

Over the years I have been reluctant to propose lowering the age of retirement when, as a matter of fact, advances in medical science and a better way of life are increasing life expectancy more and more. Notwithstanding this feeling, I cannot have too much objection to the provision providing actuarially reduced benefits for widows at age 60, and I would emphasize the point that to choose retirement at an earlier age, the benefit must be reduced, to keep any kind of system actuarially sound.

I believe the provision liberalizing the definition and waiting period for disability insurance benefits has a great deal of merit.

I am particularly glad to see the provision increasing the amount an individual is permitted to earn without losing benefits.

Mr. Chairman, I wish it would have been possible to include all these improving amendments in one package and set apart from the real "hooker" in this legislation, and that is the hospitalization section of the bill—the so-called medicare provision—which is financed through the medium of a payroll tax on wage earners, many of whom may be least able to pay for medical insurance for others, and who themselves cannot participate in the benefits until age 65.

I have referred to the medicare section of this bill as the real "hooker" in the legislation, for if we were to vote on it as a separate provision, I am confident it would be soundly defeated. It cannot, as a matter of fact, stand on its own, and that is the reason we find it enveloped in all these "goodies"—that is, improving amendments to the current act that I have previously alluded to. We are actually being blackmailed here to take medicare along with the good features of the bill, or we are going to have to vote against the whole proposition.

I have a real concern for the future and those millions of our elderly citizens who are counting on social security benefits as their sole source of income for retirement. With this medicare feature, and its attendant increased payroll taxes, we are going to find ourselves in a position in a few years where the Congress will not be able to provide cost of living increases in retirement benefits because we have preempted the tax base for this medicare feature. I would

point out, Mr. Chairman, that we are not only increasing the base from which we take the tax from the current \$4,800 to \$6,600, but we are also increasing the rate for the employee and the employer. As a matter of fact together by the year 1973 the total social security tax from employee and employer will be 10.6 percent. By the year 1987 with no additional improvements or broadening of the coverage the tax will be 11.2 percent. Now for the self-employed, and this would include that great number of farmers in our congressional district, the tax will be raised to 7.5 percent by 1973 and 7.8 percent by 1987.

Let us make no mistake about it, this payroll tax is a regressive tax, and let me cite if I might, just a few figures that our young people ought to take to heart.

Do you realize that if a young worker begins working next year—1966—at the age of 21 and has deducted from his paycheck the full amount of these social security taxes for the next 44 years, until he reaches retirement at age 65, he could have, if he were to invest his deduction, plus his employer's deduction, at 4 percent compounded interest, a nest egg after 44 years of approximately \$81,000. Now, if he were self-employed over the same period and in the same given set of circumstances, he would have a nest egg of better than \$55,000.

Not only are these increases in tax frightening for the individual, but they should cause great alarm and concern for business and industry to compete in the future. For example, a telegram I have just received from Caterpillar Tractor Co. reads in part as follows:

H.R. 6675 abandons criterion of need. Heavy cost to employers will decrease competitiveness of U.S. firms in world markets at same time administration requesting manufacturers to increase contributions to international payments flow. The two positions do not square with each other.

Mr. Chairman, I said at the very outset of my presentation here this afternoon that I find myself in a very difficult situation, for I should like to vote for the good features of this bill and vote to cut out the bad features, as I see them. But under the closed rule under which we are considering this measure, I do not have that opportunity. And so, I am going to vote for the motion to recommit the bill with instructions to implement our Republican-sponsored substitute, which for all practical purposes provides all the benefits, except the objectionable medicare feature, financed with a social security payroll tax.

If the motion to recommit fails—and I suspect with the overwhelming odds against us, it will—I believe that notwithstanding all the good features of this legislation, I will be compelled as a matter of conscience, to vote against the bill on final passage, to point up the great concern I have for the future integrity of the social security system, and the tremendous increase in tax burdens that will be involuntarily thrust upon every working man and woman in this country.

As a matter of fact, in this morning's mail I received a letter from Mr. Peter Cioni, secretary of Local Union No. 422, International Hod Carriers, in which he says:

When are the politicians going to tell the public the truth of how social security benefits are derived at and how the low-income groups' benefits keep shrinking each year despite these 7- or 8-percent increases. Those increases sound good, but politicians being what they are, Republicans and Democrats alike, fail to tell the story that each year as the base from which benefits are derived are raised. Despite these increases, those who need these benefits most, benefits keep getting smaller and smaller, and those in higher income brackets who need them least, get bigger and bigger.

I should point out that several years ago I introduced my own health care bill that would have met this problem by way of an income tax credit in the amount of the premium that individuals would be paying for their medical care insurance.

I do believe our Republican substitute here this afternoon is a very comprehensive program, financed partly by premium contributions and partly by general revenues. The relative advantages of the Republican proposal are as follows:

The basic hospitalization program in the committee bill is extended automatically and compulsorily to all eligible persons over 65. The Republican program would be wholly voluntary. When coupled with the payment of a premium contribution, this reduces the duplication of coverage for those already covered under private programs. It preserves the insurance concept.

In the committee bill, the hospital program is extended to all persons presently over age 65—except certain Federal employees—at no cost. The Republican program requires the participants, including those presently over age 65, to make a contribution toward the cost of their insurance. This reduces the cost which under the committee bill must be borne by taxpayers under age 65. It also acts as a deterrent to excessive utilization of benefits on the part of those enrolled.

The hospitalization program in the committee bill, is, in fact, a part of the social security tax system. An additional liability of upwards of \$100 billion is imposed on the social security tax structure by the adoption of that program. The Republican program is financed out of the general revenues, wholly apart from the social security system. This reliance on general revenues utilizes the general tax system, based on ability to pay. It avoids the regressive payroll tax and does not jeopardize future increases in cash benefits.

In financing the hospitalization program through the payroll tax, as a part of the social security system, the committee bill gives rise to the concept of "entitlement." It creates the erroneous impression that the wage earner is "pre-paying" for a specific hospital benefit. This precludes revision of benefits in the future, except to increase the scope of the program. The Republican program preserves the ability to revise the programs as conditions dictate. When the insured is required to pay a premium for the benefits, both premiums and benefits can be modified as the need arises.

Benefits of the combined hospitalization program and medical services program in the committee bill fall short of

the benefits provided for in the Republican program. The committee bill does not meet the problem of the catastrophic illness. The Republican program covers the catastrophic illness up to a lifetime maximum of \$40,000 in benefits. The Republican bill also covers prescribed drugs while the committee bill excludes this item.

The Republican program provides these more extensive benefits at a lesser cost. By eliminating duplication of coverage and combining all medical benefits in a single comprehensive insurance program, the Republican program will provide more protection for less dollars.

The committee bill offers hospital and medical service benefits to the aged without regard to need. The Republican proposal provides for premium contributions related to cash benefits under social security, coupled with a tax recoupment of the subsidy attributable of individuals with incomes over \$5,000. This eliminates "need" as a basis for qualification without extending benefits to those who are, in fact, able to pay the full cost of their insurance.

The Republican proposal also incorporates the underlying principles proposed in the eldercare bills. It makes specific the right of the States to enter into private contracts of health insurance for those eligible under the State-administered old-age assistance and medical-assistance-for-the-aged programs.

In conclusion, Mr. Chairman, may I say that we have recently circularized our district with questionnaires, posing two specific questions on this subject. While we have received about 15,000 returns, we have not yet had an opportunity to tabulate them, but in just a spot check of 100 we find that on the question, "Do you favor 60 days of hospital and nursing home care for those over age 65, financed by added social security taxes, under a compulsory program?" A reply of 14 yes, 73 no, and 13 undecided.

In reply to the second question, "Do you favor medical, surgical, hospital, nursing home, and drug benefits for those over 65, financed by a tax credit or from general revenues for private insurance, under a voluntary program?" we received a reply of 70 yes, 18 no, and 12 undecided.

Mr. Chairman, I suspect that complete tabulation of our questionnaire will pretty well bear out this ratio, since our spot check was taken completely at random, with no thought of prejudicing the outcome.

Notwithstanding this tabulation, there is no question but that the popular vote here in the House today is going to be one in support of this legislation on final passage, but I for one, as I have indicated in the course of my remarks, will be one of those voting for the motion to substitute the Republican proposal and if that fails, to vote against the bill on final passage, and hope that it helps to draw attention to this horrendous tax burden that is going to be thrust upon every American and every future generation.

Mr. DANIELS. Mr. Chairman, I am proud to rise in support of H.R. 6675.

This week we are witnessing the end of a 20-year struggle to provide a better life for our senior citizens. There are still many Members of this House who can remember stalwart battlers for this type of program like the late father of our distinguished colleague from Michigan, the Honorable JOHN D. DINGELL, whose fame as a champion of medical care for the aged spread from coast to coast. As a newer Member, I am proud to have had the privilege of serving with former Congressman Aime Forand of Rhode Island, the sponsor of the original medicare bill, to whom this victory will be especially sweet. No one deserves more credit for his support of our aged than the sponsor of H.R. 1, the basis for this legislation, the very able gentleman from California, CECIL KING.

Briefly, the bill provides 60 days of hospitalization during each period of hospitalization for all persons who have reached the age of 65, financed by an additional tax on employers and employees under the social security system, and the Railroad Retirement Act. Those persons over 65 who are not covered by railroad retirement or social security will receive medical care financed by general tax revenue.

The committee plan provides additional care for those who require medical attention after leaving the hospital. The bill allows posthospital care up to 20 days after each stay of 3 days or more in a hospital.

H.R. 6675 provides outpatient diagnostic care with a \$20 deductible feature for services provided by the same hospital during a 20-day period. If, however, within 20 days after receiving the outpatient diagnostic care the patient became an inpatient in the same medical facility, the \$20 he has already paid would be credited to the \$40 he would have to pay as an inpatient.

The bill also provides for 100 visits to the home of the patient by a nurse after being discharged from a hospital or nursing home.

In addition to the basic plan which is similar to that proposed in H.R. 1, the Ways and Means Committee has added a supplementary plan to cover doctor's fees. Elderly citizens can obtain this coverage by paying a \$3 monthly premium which can be deducted from their social security payments. The Government will match this \$3 premium with a similar contribution from general tax funds. The State could also obtain the benefits from the supplemental program by enrolling their old-age recipients and paying the premium.

I am happy to support the provision granting a 7-percent across-the-board increase in social security monthly benefits with the added provision that no recipient shall receive less than a \$4-a-month increase. It is hard to imagine in this rich and prosperous Nation that we have senior citizens eking out a meager living on such a small monthly income, but such are the facts. Every great city has its neighborhood of shabby lodging houses where these poor people, lonely and destitute, struggle to keep body and soul together. These are not

mendicants or parasites but honest Americans who have fallen victim to the crime of growing old without means to support themselves after their productive years have ended. I commend the committee for including this feature into the bill. Naturally, I would have hoped it would be larger, but to these poor people living at a marginal level even a little bit is a lot.

I am of course glad to see the provisions of the Kerr-Mills bill improved by providing more generous financing of the health care to needy children under the program for dependent children. Similarly, the provisions of the Kerr-Mills Act under H.R. 6675 will be extended to the blind and the permanently, totally disabled.

This bill also increases the Federal contribution for the maternal and child health services by \$5 million for 1966 and by \$10 million for each succeeding year. Similarly, the Federal contribution for crippled children will be increased by the same amount.

Candor requires me to state this bill is not all that the Congress might enact, but, on the other hand, it is the most outstanding piece of legislation in this area that has ever been brought before this House. Those who oppose this bill but cloak their opposition by saying that this bill does not go far enough have argued that this bill does not cover all the medical needs of our senior citizens of the United States. But they fail to mention that this bill does more than any bill that has ever been voted upon in this House.

Mr. Chairman, I am proud to support H.R. 6675. Every Member who votes today in favor of this bill can say that he has done his share in a great cause. This is a great day for every American who feels that we have an unending obligation toward our older Americans. They have done much for us. Now it is our turn to do just a little for them.

Mr. CLANCY. Mr. Chairman, liberalization of social security eligibility requirements and increases in benefits are overdue. I strongly supported making the necessary adjustments last year when we approved the Social Security Act amendments that would put benefits in line with the rising cost of living. Social security recipients would have been receiving larger checks each month for some time now had the bill not been saddled in the Senate by inclusion of the administration's compulsory hospitalization plan which the House conferees would not agree to.

To insure that the more than 20 million beneficiaries of the social security program enjoy at least minimum standards of health and comfort, I introduced earlier this year a bill (H.R. 4144) to increase benefits by 7 percent. My bill would continue benefits to age 22 for children attending school and would provide actuarially reduced benefits for widows at age 60. In these respects my proposals do not differ from the bill under consideration today.

In fairness to older persons who were unable to acquire the necessary quarters of coverage, my bill would liberalize the

eligibility requirements so that certain persons 70 years or older could qualify for minimum benefits. The administration's bill would require that these persons attain the age of 72 before being eligible.

My bill would also provide greater liberalization of the retirement test. Because many elderly persons must or desire to work to supplement their social security payments, I included a provision which raises the amount of outside earnings a social security recipient can receive without penalty to \$3,000.

I bring this up today because I want to make it crystal clear that I favor those portions of the bill under consideration today which would improve our social security system.

At the same time, I want to make it equally clear that I am strongly opposed to the concept of financing of hospital benefits through the social security system. In good conscience I cannot vote for the imposition of a regressive payroll tax on wage earners, many of whom may be least able to provide hospitalization and other kinds of health care to persons over 65, regardless of their financial needs. H.R. 6675 would impose upon today's workers a liability of approximately \$35 billion for hospitalization benefits just for those already over 65.

A worker entering the work force at the age of 21 will pay a payroll tax for 44 years, which his employer will match, to finance health care benefits if this bill is approved. The actual cost of the hospitalization program per worker entering the work force at age 21, with interest at 3½ percent per year, will amount to \$8,590. If the same amount were invested in private health insurance, the worker could obtain far more extensive benefits than are provided under the hospital program contained in the bill.

In not voting for the administration's compulsory hospitalization plan, I follow not only the dictate of my conscience, but also the wishes of an overwhelming majority of the fine people I am privileged to represent, the residents of the Second Congressional District of Ohio. For the RECORD, I include the results of a preliminary tabulation of their answers in response to a multiple-choice question on medicare asked in a recent opinion poll I made. Each major program was briefly and impartially summarized, and the respondent was asked to check the one he favored:

Percent

King-Anderson bill.....	9
Bow bill.....	16
Curtis-Herlong eldercare bill.....	47
No Federal participation.....	20
No answer.....	8

It is obvious from the foregoing figures that less than 10 percent of my constituents who responded subscribe to a compulsory Government hospitalization program. And, frankly, I am inclined to believe that the percentage would be even smaller if all those who favor this approach realized the ramifications of this far-reaching welfare proposal—chief of which are the inevitable regimentation of medicine, possible deteri-

oration of the quality of health care judging from past experience in other countries, and soaring costs.

I would also like to point out that I think it is particularly significant that one-fifth of the respondents favor no Federal participation in this field.

Their reasoning is no doubt predicated on the fact that where you have Federal participation you risk Federal interference. In an attempt to mollify those who do not want bureaucrats in Washington running their lives, the drafters of the legislation insert a statement that any Federal interference is prohibited. If you only read to page 9 of the bill where the prohibition against Federal interference appears, you might believe this. But if you read the next 70 pages, you will see how the Federal Government plans to run the show.

In place of the Ways and Means Committee bill, the minority Members offer us a substitute measure which would be voluntary rather than compulsory, provide more comprehensive benefits, and would be financed partly from general revenues and partly by payments by those participating. No compulsion. No threat to the integrity of social security cash benefits. No discriminatory eligibility provisions.

I support the concept that adequate health insurance should be made available to the aged at a reasonable cost. But I believe such a program should be voluntary. Therefore, I will support the motion to recommit the committee bill with instructions to substitute in its place the Republican bill, H.R. 7057. This bill would make all the improvements in the social security system proposed in the administration bill but would substitute a voluntary program of health insurance for the compulsory plan.

Mr. YATES. Mr. Chairman, seldom has a subject received a more searching or extended examination than the subject of health care for the aged. This issue has been talked about, discussed, analyzed, debated, and argued in every part of our country. Numerous bills have been introduced in previous sessions of Congress and some were nearly enacted. The volumes of testimony taken during the congressional hearings into this subject would fill a small library.

During this long period many of us were impatient over what seemed to be an endless series of roadblocks and delays. And finally today, the drive of a decade is nearing its goal as we are about to pass a truly historic bill which will protect the health and dignity of our elderly citizens.

If it takes a decade to perfect a medicare bill, then I say it has been a decade well spent, for the bill before us today is a remarkable example of legislative craftsmanship. Perhaps the Roman poet Ovid was right when he wrote "Delay matures the tender grapes and ripens grass into luscious crops." One by one, the criticisms and charges leveled against previous medicare bills have fallen by the wayside.

It was once charged that medicare ig-

nored those not on social security. Now, virtually all older Americans are included in the bill.

It was charged that doctor bills would not be covered. Now, the bill includes a voluntary plan to cover doctor services.

It was charged that doctors would be placed under the bureaucratic direction of the Social Security Administration. Now, the bill finances all doctor services through existing private insurance organizations such as Blue Cross.

It was charged that medicare might someday bankrupt the social security trust fund and jeopardize future retirement benefits. Now, the bill sets up a separate trust fund for hospital care. Both are actuarially sound.

It was charged that medicare ignored the existing Kerr-Mills program of aid to the needy. Now, the bill expands and improves the Kerr-Mills program as a supplement to health care for all elderly citizens.

Mr. Chairman, I think every Member of Congress will agree that we have a serious problem in providing for the health of our elderly citizens, and I am sure that every Member wants to do something about it. What are the dimensions of this problem?

There are 18 million people over 65—about 10 percent of our total population—and the percentage is increasing. Most of these people are poor. The average income for an elderly couple is about \$2,500 a year—or below the poverty level of \$3,000 established in the antipoverty program. One-third of the old people have no assets and one-half have less than \$1,000.

The medical needs of older people are greater. They go to the hospital three times as often as younger people, and they stay twice as long.

Most of these elderly people do not have adequate incomes or savings to provide for the health care they need. Although private insurance is available, most elderly citizens cannot afford comprehensive coverage.

Mr. Chairman, I believe the bill before us, H.R. 6675, is an effective answer to these problems. The distinguished chairman and members of the Committee on Ways and Means are to be commended for reporting it to the House. It is a reasonable and carefully designed proposal which combines the best features of the original administration bill, the AMA-sponsored eldercare bill, and the bill sponsored by the gentleman from Wisconsin [Mr. BYRNES].

The bill will provide up to 60 days of full hospital care per illness for virtually all Americans over 65. This part of the program will be financed through a separate payroll tax similar to social security.

Secondly, it provides all persons over 65 with a voluntary plan covering physicians and surgical services; care in mental hospitals; home health services and other medical services. Persons who choose to participate will pay premiums of \$3 a month which are matched by the Federal Government. The plan will pay 80 percent of all bills in excess of an annual deductible of \$50.

The third part of the bill expands and improves the existing Kerr-Mills program. It extends coverage to needy persons who are handicapped and requires the States to offer a minimum level of services and to establish a flexible income test.

And finally the bill improves the existing social security program and raises benefits by 7 percent.

What will this bill mean to the average citizen? It will mean that for the first time in our history, Americans will be able to live out their declining years free from the worry of crushing medical expenses. No longer will they need to live with the haunting fear that tomorrow may bring an illness which will sweep away their small savings, their home, their security, and compel them, for the first time in their lives, to apply for relief.

Younger people with elderly parents will not be burdened with heavy medical bills at a time when their own family expenses are greatest. Many of our younger people have had to make severe financial sacrifices in order to meet their parents' medical expenses. All too often, funds diligently saved up for a college education or new home disappear overnight to meet the unexpected and catastrophic medical bills on an aging parent.

But this bill provides dignity as well as dollars. The hospital care portion financed through the social security system is a form of insurance and not charity. Each person pays into the fund during his productive years and is entitled—as a matter of right—to adequate hospital care in his later years. He need not pass a degrading means test or go on relief to prove his eligibility.

Mr. Chairman, I have received a good deal of mail on the so-called eldercare plan sponsored by the American Medical Association.

The principal criticism advanced by the eldercare advocates was that the administration bill covered only hospital expenses and did not cover doctor bills. I am glad to see that this defect has been remedied. The bill now before us contains a voluntary plan for doctor services at a price which elderly people can afford.

However, many of the other claims advanced during the AMA's campaign on behalf of eldercare did not make sense. For example, they would have us believe that somehow, by some financial sleight of hand, eldercare would provide more benefits at less cost. How can this be possible? A medical expense is a medical expense and it is going to cost the same regardless of the financing method. There is no magical shortcut to cheap medical care. Actually, the administration's social security approach is somewhat cheaper because it costs less to administer.

Equally misleading were the glowing descriptions of the benefits available under the eldercare bill. Even the sponsor of the bill had to publicly complain about some of the misleading advertising which was put out in behalf of eldercare. These benefits would depend upon a State's decision to participate. Most States simply do not have the money.

And so, Mr. Chairman, we are about to embark upon a new era in meeting the needs of our elderly citizens.

We are about to extend its time-tested principles to the field of hospital insurance. I anticipate that within a few years, hospital insurance through social security will also achieve the near universal support the social security program—that is old-age and survivors disability insurance—now enjoys.

Mr. McGRATH. Mr. Chairman, passage today by the House of Representative of this medical care measure will be a giant step toward the most comprehensive program of medical assistance to senior citizens anywhere in the world.

The bill which we can adopt today provides far wider coverage than we dared hope for when the 89th Congress convened in January. Combining the best features of medicare and eldercare in its provisions, the bill's passage will be considered a red-letter day for our Nation's elderly citizens.

Furthermore, liberalization of social security benefits included in the measure's provisions will be a boon to all Americans, particularly the section providing a 7-percent hike in social security payments.

I am proud to be a Member of this Congress, which has moved toward fruition a much-needed health-care plan which has been debated for some four decades.

I, therefore, urge all Members to vote against recommitment of this bill and to vote for final passage of this great medicare bill.

Mr. RONAN. Mr. Chairman, I take particular pleasure in supporting the provision of H.R. 6675 under which benefits will be paid to children age 18 to 22 who are in full-time school attendance. This is an especially fine and forward-looking provision. It will extend the survivorship protection of the social security program and enhance the educational opportunities we offer our young people.

A child who has lost parental support through the retirement, disability or death of his mother or father is considered dependent under the present social security program if he is under age 18 or if he has a disability which began before he reached age 18. I strongly concur in the committee's view that a child who is in full-time school attendance after reaching age 18 is similarly dependent. It is simply not realistic today to stop a child's benefits on his 18th birthday and tell him that he is now presumed to be able to go to work and to support himself. While some children can and do become economically independent by the time they are 18, most children cannot be financially independent at 18 because they have not finished high school, and they must look for a living to an economy that has little use for the untrained, unskilled, and uneducated worker. It is time we recognize that this is the situation, that this situation will continue, and that a child who has reached age 18 and is still continuing his education is as dependent on social security benefits to replace lost parental support as he was when he was younger.

Under the bill about 295,000 children age 18 to 22 would get benefits this September, when the school year begins. Many of these youngsters would not be able to continue their education without the benefits this bill will provide. It will mean a great deal to them and to their parents, so many of whom have written to us asking that the benefits be continued.

Mr. ST GERMAIN. Mr. Chairman, I am more than proud today to speak in support of the Social Security Amendments of 1965.

My predecessor, Aime Forand, was the pioneer in this field. It was he who in 1956, first introduced legislation providing for medicare for our senior citizens. He retired from the Congress prior to its passage, but he left a legacy to his successors and this is his crowning achievement.

The principle embodied in his original legislation is carried through in the legislation we are considering today. When he first introduced the measure, he knew that it would undergo a great deal of amendment. He knew the fight would be long and hard. He knew that the opposition would be strong and that opponents of the legislation would fight right to the end of the line. But, he also knew that the principle of medicare for our senior citizens was desired by the people of the United States, because it was, and is an absolute necessity.

The legislation we are to vote on today, fortunately goes further than the original measure in many respects, and unfortunately does not go as far in others.

This legislation is a tribute to the members of the House Ways and Means Committee who worked so hard and diligently. It is a tribute to Aime Forand, to the late President John Fitzgerald Kennedy, and to President Lyndon Baines Johnson, each of whom put all the weight of their offices and all the strength at their command behind it.

It is a tribute to the people of America—the thousands upon thousands—the millions—who took time, year after year, to write their Members of Congress and inform them of their burning desire and keen interest in this legislation.

This legislation goes beyond providing for medicare and the voluntary insurance program—it also embodies many improvements to the social security system.

The Ways and Means Committee and its staff have gone to great lengths to insure that these benefits will accrue to the people for whom they are intended. I do hope and pray that as a result of these increased benefits the individual States will not attempt to take advantage of these people who need additional help by effecting decreases in the help now being provided. The legislation has been carefully drafted to avoid any such occurrence, for we have seen it happen in the past. I realize there are those who may seek loopholes—but let there not be any loopholes.

The Great Society continues to move forward and this legislation, in my opinion, and in the opinion of many

Americans, is the greatest stride it has taken to date.

Mr. DENT. Mr. Chairman, I am honored to rise today in support of H.R. 6675, the Social Security Amendments of 1965. My sincere congratulations go to the gentleman from Arkansas and his able committee for presenting the House with a bill upon which all parties interested in the welfare of the elderly may securely stand. It is not only a milestone in our legislative deliberations, but is also a masterpiece of equity and compassion.

Mr. Chairman, it is entirely appropriate for me to note that the great majority of mail coming into my office concerns the very subject of health care for the elderly. The medicare versus elder-care controversy will probably be remembered by all of us as one of the most heated within memory's reach. It is not only a credit to the gentleman from Arkansas and the committee on Ways and Means, but a credit to the Congress that this bill embodies the best features of both proposals. It is difficult for me to recall in my experiences, any other legislation, either before the House or the legislature in my own State, which has been worked on more diligently and which considers the vast differences of opinion on the necessary character of the legislation than does this legislation.

The bill before us is referred to as the Social Security Amendments of 1965. This package includes long-overdue and well-needed increases in OASDI benefits. Its main thrust, however, is obviously in the provisions for health care insurance. In light of this, I would like to address the remainder of my remarks to this new feature of our social security program.

Mr. Chairman, it is not the responsibility of the Federal Government to look throughout our society in search of potential responsibility. This would not only be contrary to our entire system of government, but especially contrary to our great and lasting Constitution. It is the responsibility of the Federal Government, however, to satisfy a need—in this instance a physical and social need—when such need is not presently nor properly being met. It is further evident that the individual States cannot meet the problems of the elderly as regards basic health protection. It is therefore incumbent upon the Federal Government, and in accord with our traditions, to provide relief for those who suffer through no or little fault of their own. This is not a giveaway program, nor is it per se a welfare program. It is an insurance program, much of which is voluntary.

This program does not demand a statement or confession of desperate financial inability or the familiar "means test"—and it properly should not. We have already had an experience with that force and found it practically useless. No self-respecting citizen, despite the financial strains upon him, would think of placing himself at the doorstep of welfare and acknowledging his desperate condition before a public entity.

Mr. Chairman, we are a proud and self-respecting people. I daresay that

our pride and self-respect is more important to us than most else in life, including our physical condition and social status. This bill will do nothing to provide more individual virtue; but it will, on the other hand, not force many to sacrifice individual virtue. The alternative proposal would do exactly that. They would force a man to swallow hard and lay open his private business for all to see. They would force him to plead poverty and ask for help. The bill before us asks no such sacrifice.

Although it is true that many who can afford basic hospitalization charges will nonetheless be eligible for these new social security benefits. It is also true that millions more who cannot afford such charges will likewise be eligible. These millions are the rightful concern of the Federal Government, and the legislation before us recognizes that concern and accommodates it.

Mr. Chairman, approximately one-tenth of our citizens are over 65. In my own district, some 35,000 good people are aged 65 or over. I am concerned because they have contributed so much to our country in its development and progress and in the defense of its ideals. They are entitled to anticipate their later years with hope and a feeling of security. They should not have to live their years in fear or despondency and drift. I therefore ask the House to acknowledge these citizens and their problems with compassion and understanding. Let us rise as one and remind them, as well as ourselves, that we do recognize their contribution as well as their needs; and let us rise as one and play our role in their future security.

Mr. FINDLEY. Mr. Chairman, this legislation is so completely centered on methods of financing for medical services, that an important, plain fact is almost obscured from sight.

That fact is this: The medical needs of our elderly citizens are being met today in a superior manner. Those who go without needed medical care are rare exceptions. I have substantial evidence in support of that statement.

Our private medical care system does serve well the needs of the American people. It is regarded as the best the world has ever known. It can and should be improved still more, but let us give credit where it is merited.

To the best of my knowledge, no one has contended that the total effect of this legislation will make medical care in the United States still better. It will make for a substantial change in paperwork, and in the methods of financing medical bills, but it will not increase the number of doctors. It is not apt to make the medical profession more appealing for young people planning careers. So far as I know, it will not add one single additional hospital bed.

On the other hand, it may have an adverse effect on medical care. Judging from the experience of Britain with a similar system, we will have difficulty maintaining our present doctor-patient ratio.

However, my purpose at this moment is not to argue the effect of this legislation on the level of medical care, but

rather to provide some solid evidence that the medical needs of the people are presently being met in a superior manner.

For more than a year I have conducted in my home district a continuing survey of medical needs. I have done it through what I describe as my medical care referral service.

This service has convinced me that the medical needs of the 445,000 people in my district are being adequately met on surprisingly complete basis.

The drumfire of publicity in behalf of the King-Anderson approach to medical care for the elderly has been continuous during the 4 years I have served in the House of Representatives.

One result of all publicity, I am sure, was to widen the illusion that the health needs of elderly citizens are not being met adequately. The Kerr-Mills program never got the attention it deserved.

In Illinois, for example, my experience indicates that few people ever heard of Kerr-Mills, and most of those who have heard about it have misconceptions concerning it and the way it is administered.

On February 26 of last year, I began my medical care referral service, intended mainly to provide information to constituents about the Kerr-Mills program in Illinois and to assist them in getting medical care if cases of inadequate care were found to exist.

My announcement was carried widely by press wire services. The text follows:

WASHINGTON.—An Illinois Congressman today announced his own medicare program. Representative PAUL FINDLEY, Republican of Illinois, has promised prompt medical attention to any constituent who is not getting adequate medical care.

He said, "Doctors in each major community have assured me of their full cooperation in making this possible." Explaining his new service in a statement issued yesterday to constituents, FINDLEY said,

"All Americans should receive the medical care they need, regardless of personal financial circumstances. This is a principle to which I heartily subscribe, and one that is well rooted in our way of life.

"If you know of anyone in the 20th District who is not getting adequate medical care, please let me know.

"A number of medical service programs, both public and private, are available to help needy citizens. The most recent in Illinois—and perhaps the least known—is the Kerr-Mills program, which provides full reimbursement of all medical expenses to those over 65 who are in need.

"Unfortunately, many people are not aware of what is available, and perhaps occasionally some will go without needed medical care for lack of information. My referral service is intended to meet this problem."

In preparation I had consulted several times with Newton DuPuy, M.D., an official of the Illinois State Medical Society and an outstanding member of the medical profession in Quincy, Ill. He supplied me with the names of doctors in each community who were willing and anxious to cooperate in a referral service. Twelve of the fourteen counties were represented in this list of physicians. The two exceptions were small and sparsely populated, served largely by nearby medical centers.

From the date of announcement to this date, I have had 382 individual responses, almost all of them letters. Other Congressmen in Illinois have had inquir-

ies, I might add, because news of my referral service appeared in newspapers throughout the State. Several of them asked me for details on how I have handled this service.

During the first 4 months, I referred each letter immediately and directly to the doctor on my referral list located nearest to the person involved. This was done regardless of the content of the letter.

My acknowledgment letter read as follows:

Thank you for writing to me concerning your medical care problem. I am transmitting your letter immediately to a medical doctor who is cooperating in this service, and I am sure you will be contacted soon.

Thanks for giving me this opportunity to be of service.

If the letter concerned the medical problem of someone else, the first sentence was altered accordingly.

At the same time this transmittal note was sent to the doctor selected from my referral list:

Thanks very much for cooperating in the medical care referral service. As you know, in announcing the service I asked to be informed of anyone in the 20th Congressional District who is not presently getting adequate medical care.

The enclosed letter is a response to my announcement. I will count on you to get in touch with the person involved—or see that another medical doctor does so—and to do whatever you consider to be warranted.

I would appreciate a note from you indicating ultimate disposition, together with any impressions or suggestions you may have.

Your fine cooperation is deeply appreciated.

Copies of correspondence were sent to the Illinois State Medical Society office in Springfield.

You will note that my announcement did not concern the medical problems of the elderly only. Constituents were invited to notify me of anyone not getting adequate medical care. The invitation was intentionally broad. You will note also that the payment aspect of medical care was not mentioned in any way.

Since making the initial announcement, I have repeated the same basic information in speeches throughout the district, and in several newsletters to constituents. I will continue to publicize it as widely and as frequently as I can.

The response was much smaller than I had anticipated, especially so in view of the broad character of the invitation.

After 4 months of direct contact with physicians, I changed somewhat the referral procedure. All responses are now transmitted directly to the Springfield office of the Illinois State Medical Society, where Harold Widmer does the initial checking.

The change was made in the interest of efficiency for all concerned, to make possible maximum speed in processing and to make the load as easy as possible on the doctors who are cooperating.

Mr. Widmer usually makes a telephone call to the Department of Public Assistance, usually checking directly with the county office nearest the person involved. The check turns up any case history which may be on file. Usually, he will then telephone the person whose medical care is involved. Sometimes, the case

is adequately settled by telephone. In other cases, personal interview with a nearby physician is arranged.

Of the 382 letters only 6 cases suggested the possibility that someone was not getting adequate medical care.

In many cases, the person contacted felt better, with a more confident mental outlook. Many of them had never heard of the Kerr-Mills program, and were comforted to know that such a program existed whether they themselves qualified at that time or not.

Several qualified for assistance under this program as the direct result of the referral service. I do not know the exact number, because I have had no reason nor desire to pry into details.

Since changing to direct contact with the Illinois State Medical Society, I have begun to supply information on Kerr-Mills directly in the cases where information seems clearly to be the only need. The information I supply is duplicated, as follows:

ILLINOIS MEDICAL CARE INFORMATION, KERR-MILLS

This is a system of Federal matching grants to provide medical care to the needy aged. It helps those who are otherwise self-supporting but unable to pay medical bills. It became effective in Illinois on August 1, 1961.

A. SERVICES PROVIDED

1. In-patient hospital services.
2. Physicians' service during hospitalization.
3. Physicians' visits for 30 days after hospitalization.
4. Drugs and medications for 30 days after hospitalization.
5. 90 days nursing home care (convalescent or rehabilitation) following hospitalization, including physicians' services and necessary drugs.

B. GENERAL ELIGIBILITY REQUIREMENTS

A resident of Illinois, 65 years of age or older, is entitled to benefits when:

1. Annual income from all sources does not exceed:

Single person..... \$1,800
2 persons (spouse and dependent) --- \$2,400

(Add \$600 for each dependent.)

2. Cash and marketable assets do not exceed:

Single person..... \$1,800
2 persons (spouse and dependent) --- \$2,400

(Add \$400 for each additional dependent.)

In determining amount of marketable assets, do not count:

1. Homestead and contiguous real estate.
2. Automobiles, household furnishings, clothing.
3. Life insurance with cash value up to \$1,000.
4. Personal property used in producing income.

C. ADMINISTRATION

Administered by the Illinois Public Aid Commission through its county departments of public aid. Those in the 20th Congressional District include:

Adams County: 640 Hampshire Street, Quincy.

Brown County: 233 West South Street, Mount Sterling.

Calhoun County: 308 South County Road, Hardin.

Cass County: 209 West Second Street, Beardstown.

Greene County: 425 South Fifth Street, Carrollton.

Hancock County: 526 East Locust Street, Carthage.

Jersey County: 215 South Jefferson Street, Jerseyville.

McDonough County: 124½ North Lafayette Street, Macomb.

Macoupin County: 213 North East Street, Carlinville.

Morgan County: 205 West State Street, Jacksonville.

Pike County: American Legion Building, Pittsfield.

Sangamon County: 628 East Adams Street, Springfield.

Schuyler County: 213 West Washington Street, Box 111, Rushville.

Scott County: 128 West Cherry Street, Winchester.

D. FINANCING

Federal Government provides 50 percent of the cost of operating Kerr-Mills in Illinois and the rest is State funds.

Similar benefits are available to those who qualify for public welfare. For information, contact the Illinois Public Aid Commission office in your county. In many counties, assistance is available to those in hardship circumstances by township supervisors. For information, contact your county clerk. War veterans may be eligible for medical care and rehabilitation. For information, contact the Illinois Veterans Commission, your nearest American Legion post, or Veterans of Foreign Wars post, or the Veterans' Administration, Washington, D.C.

Important: When hospital care is needed, application must be made before or immediately after entering hospital. This must be done.

All letters which give even the slightest indication that someone may not be getting adequate medical care—or which present specific information problems—are referred immediately to the Illinois State Medical Society.

Our referral service has been developed by trial and error. It is now functioning smoothly and helping a number of people to get the information and assistance they need, thanks to the splendid cooperation by the Illinois State Medical Society, Dr. DuPuy and the associates he has selected, and thanks also to the truly constructive, efficient, and enthusiastic support by officials of the Illinois Department of Public Assistance, the agency which administers the Kerr-Mills program.

Now, a look at the responses. The quotations are directly from the letters. The facts and allegations are not verified.

Six letters suggested a lack of medical care due to inability to pay medical expenses. Two were directly from the person seeming to lack medical care. Here is a quote from one of these two letters:

I am writing about information on the Kerr-Mills medical assistance for the aged program as I am on the low-income social security. I was in the hospital 9 days last July with pneumonia—had to go back for a recheck. The _____ Co. paid a part of my bill, but by borrowing from the bank and the help of my sister, the hospital bill is paid, but I have been unable to pay my doctor bill up to date, so I have not been doctoring, as I want to pay on doctor bill first. Please let me know if I have any assistance as there is always none left on \$40-a-month social security.

Four letters were from friends or relatives. Here are three typical quotes:

A minister wrote:

A lady from our church and from your district recently had major surgery. She had a little hospitalization insurance but not enough to cover the bill by any means. She didn't want the surgery because she didn't know how she would pay the bill, in fact she left the hospital the first time and then had to be taken back and have the surgery. My concern and question is, Would the Kerr-Mills program be able to help Mrs. — with her medical bill?

From Adams County:

My wife's father was in need of a doctor. He called one and the doctor very plainly told him if he had \$25 in cash he would come to see him. If not he should come to his office. Mr. — did not have the money and the doctor would not come. At this time he is in need of medical care. I know of other people right near here that cannot afford to go to the doctor—they just can't pay the charges.

From Springfield:

My mother, who is 78, fell about 2½ years ago and broke her left hip. She is now an invalid who suffers very much and is in generally poor health. I love my mother dearly, but we can't afford her medical expenses and right now she needs a doctor and medicine. We do everything else for her that we can, but we have gone broke from our own medical expenses. The last time she was sick, I called the office of public aid but was refused any help. There is more mercy shown our animals, we just shoot them, but our elderly are left to commit suicide or worse.

Twenty-nine letters asked for general information on the Kerr-Mills program, without stating specific problems. Several of them sharply questioned certain provisions of the program, for example, contending they would risk losing their homes by accepting Kerr-Mills assistance. This, of course, was erroneous and suggests that misinformation about the program is widespread.

Here are typical quotes:

In regard to your recent letter which we received—thank you for answering it, but we have decided not to bother about it. We own our home and pay taxes. We don't think it right to take the home property for medical care. We are paying for the medical aid and pension for aged people that haven't any home of their own. I am 73 years old and cannot get medical help or pension because we own our home.

I am most grateful for the help you have given me in trying to get a doctor and some medicine. I received a letter from Dr. — but I do not understand the Kerr-Mills program. I did not write or contact him because he mentioned the State public aid office. I had been told to go to them for help quite some time ago, which I did. However, they sent some case worker to investigate me and then sent a letter demanding that I sell my car. I have a crippled knee cap (left leg) and walk with a cane. In fact, I couldn't walk two blocks—even to get groceries.

I just can't see about the medical care. I had a stroke and in the hospital 6 weeks and a blood clot. They thought I wasn't going to come out of it and when I did they thought I would have to be sent to a home until I could be taken care of. When I got home they came around and wanted us to sign our old home over to them for us to get home help. So we knew when our home was gone we wouldn't have a place to stay.

It seems to me that the person who has tried to make his way along in life, saved some money and owns his own home, he

doesn't necessarily qualify under this bill. Whatever medical bills are paid by the county, a lien is taken against the house, and the bills are only paid as a loan. The man who saved nothing, who doesn't own a home, he is more qualified to receive this aid. Am I right?

Twenty letters were in response to my announcement, but merely took the opportunity to criticize a variety of things, such as the social security program, the public aid commission, doctors' fees.

Here are typical quotes:

I also know a doctor who came to — approximately 5 years ago, broke and not even enough money for a downpayment on a car. Today, he owns two homes plus two large farms and is considering buying a third. I am in favor of people getting adequate medical attention, but I also believe if the "squeeze" were put on these nickel-grabbing doctors, people would be able to pay their own medical bills.

If you ever hear they cut Blue Cross please let me know, as you know there are lots of poor people who can't afford it and probably would lose what they put in Blue Cross—I don't want to cause any trouble, but I wish they would quit raising it all the time.

Very unfortunately, on April 17 of this year, I suffered a hip fracture. Knowing my hospitalization would be large, I had the temerity to ask for some help through our office here. Very quickly I was voted ineligible. The denial may be due to the fact that I own my own small home and have minimum social security (\$40). Perhaps I do not understand details of plan, but my complaint is Kerr-Mills fails to live up to its commitments.

I work for a living and am a Republican but cannot see voting for something that helps some older citizens with their medical bills, and then others they will not help at all.

Now here I am about old enough to die and still worrying—69. I just got into the lower bracket of social security \$40 per month, and it doesn't go very far. I understand Canada puts the lower bracket at \$60 which would help a lot.

Having worked in welfare 18 years (12 in Illinois) I feel I know something of the need. The Kerr-Mills is a joke and as you know, so considered by many States who turned it down.

Many, many people who receive social security even in small amounts try to get along and not apply for public assistance because of their pride. They do not have money for medical bills so do not go to a doctor. Again their pride keeps them from going to P. A. offices and having all their family contacted first for help which the Kerr-Mills makes necessary.

In Montana all doctor and hospital bills were paid by the company and everyone who did not have the money to pay these bills were taken care of and it works much better than the Kerr-Mills—but I think coverage under OASI is what these people want and not county or public aid which they refuse to ask for and yet need medical care—these are poor people and do not have money for a lobby like the AMA.

The doctors sponsor Blue Cross and Blue Shield, yet they are starting to defeat their purpose. March 1 my bill for this increased almost \$1 per month. How long are self-supporting people going to be able to pay these increases that come all too often. The doctors, I realize, are busy, but must they put everyone in the hospital for a sore toe if they are insured. Also send them into the hospital overnight when it's really an out-

patient need. The doctors must surely take their share of the blame for these increases and for the need for OASI coverage for some sort of a medical plan. It's easy to see why many doctors fight this—they have really made money in Illinois under the plan now in effect—many of the hospitals favor King-Anderson or a similar bill.

Again I want to say I'm most interested in the needs of poor people and that they can get medical care needed and still keep their pride. The AMA and their lobby need no one to speak for them.

The largest category of letters—327 in all—were from people who seem to be receiving adequate medical attention but who are struggling to repay hospital and doctor bills, or are trying to pay their parents' bill while supporting their own family.

Letters giving Kerr-Mills information were sent to them, either by one of the physicians, the Illinois State Medical Society or myself. In several cases we received word that they did qualify for assistance. In most cases, however, we do not know how many followed through and were ultimately accepted for assistance.

It is apparent that many of them had no previous knowledge of Kerr-Mills and others had inadequate and inaccurate information.

Here are typical quotes:

Born in Illinois, have lived here all my life and am 74 * * * Am in need of medical help. I have arthritis and have two shots a week and lots of medicine, which amounts to a lot of money * * * We have spent our life savings and sold everything except the house we live in. Have two hospitalization insurances but there is always a balance which I am trying to pay now at—hospital. We have one daughter that helps us all she can.

I was cut off all medical aid about 2 years ago. I am 73 years old. I never could pay the doctor and hospital bills. It has been more than 10 years. Once in a while I can manage a few pain pills. Poor people should be executed when they reach the age of 50. * * * I need medical help now.

I sure hope you can help me. I am writing about my mother. She is 92 years old and has no funds whatsoever * * * The old age assistance has notified my mother that after this month, she will no longer receive the pension * * * They said her son had to give her \$70 a month * * * he isn't able to * * * When the pension office does something like this to her she sits and worries and cries all the time. * * * If there is anything you can do to help her, it would be the answer to her prayers.

Our close neighbors need medical care. The man is 86 and his wife 85. They have worked hard all their lives. They did own a home which they sold a few years ago for about \$3,000. About 2 years ago she had a cancer operation and he has a serious heart condition. That operation and their hospital and doctor bills since that time has just about taken all of their savings. They are trying to keep enough money to take care of their funeral expenses.

My total income is \$480 a year. During 1963 I spent \$252.70 alone on medicines and doctors and \$160 on health and life insurance.

My husband was 65 on April 22. On May 9 he had a stroke and was in the hospital which meant hospital bills plus doctor bills and being under a doctor's care for quite some time. * * * He is now forced to retire

and go on social security and we would like to know if we might be able to receive medical assistance. He is partially paralyzed and has not been able to talk since he had the stroke.

My wife has not been in the best of health for several years and the medical expenses have been a strain on my salary but I have managed to keep them paid. However, last month, due to anemia and a heart condition, she had to be hospitalized. * * * She was allowed to come home from the hospital twice, but I had to take her back within 2 or 3 days. Now the doctors do not know when she will be discharged. As you can imagine, the hospital and doctor bills are mounting rapidly. I do not own my home and so have nothing to mortgage to pay the bills. I would deeply appreciate any assistance you could give to help get these medical bills paid.

My wife and I have been on social security for about 8 years * * * I had a serious operation during this time which cost plenty—about \$1,000, and am at the present time under doctor's care taking medicine every day * * * monthly average medical bills approximately \$20 * * * I have no hospitalization. * * * Trying to make ends meet on \$91.70 per month. * * * Am I entitled to medical assistance?

In most respects, I am pleased with the medical care referral service. I plan to continue it. I recommend it to other Congressmen as a means of providing helpful information to constituents. If other Congressmen decide to begin the referral service, I am sure the medical societies will cooperate fully.

Indeed, I strongly urge the medical societies to take the initiative by volunteering to cooperate with any Congressmen who may be interested.

If all Congressmen, working in cooperation with medical societies, were to establish this referral service, thousands of American citizens—especially those in their declining years—would be better off, mentally if not physically. They would have confidence that government will meet all—not just part—of their medical expenses if they get in a pinch. They would know they can get this aid and still keep their home, car, and other essential items.

They would know, too, that doctors in their community stand ready to provide adequate medical care, whether they get paid for it or not.

My referral service attracted wide attention in news columns. It also resulted in this editorial, which appeared in the March 2, 1964, issue of the Illinois State Register, Springfield, Ill.:

A UNIQUE APPROACH—REPRESENTATIVE FINDLEY'S MEDICAL CARE REFERRAL SERVICE

U.S. Representative PAUL FINDLEY, the Pittsfield resident who represents this 20th District in Congress, has come up with his own medicare program, promising prompt attention to any constituent who is not getting adequate medical care. This is a unique approach to the medical care issue, and it also focuses new attention on the duties and obligations of a Congressman.

Lest someone get the wrong idea, we might explain that the Congressman doesn't plan to treat the people's medical ills himself—he's not a physician. Nor does he plan to pick up the tab for anyone's medical treatment. What he is setting up is a referral service which will direct constituents to agencies which will arrange for care and treatment. He has been promised doctors' cooperation in his efforts.

The Illinois State Register does not question the primary motives of Congressman FINDLEY in setting up his medicare program. He says he subscribes to the principle that all American citizens should receive the medical care they need, regardless of personal financial circumstances. We can only assume then that his principal reason for establishing a medical referral service is to help assure that no one goes without medical care for lack of information about availability of such care. That is a laudable motive.

But Congressman FINDLEY is an outspoken foe of proposals to establish a program of medical care for the elderly under the social security system. Could it be that a secondary motive behind the Congressman's referral service is to gather ammunition for the fight against medical care through social security? To be able to say: "Everyone in my district is being taken care of. I know because I'm seeing to it."

If this is the case, there is one aspect of the medical care situation being ignored by the Congressman. It is true that under present programs—particularly the Kerr-Mills program which FINDLEY touts—needy people can get medical aid. But the key word is needy. And a person becomes needy only after all his personal funds have been exhausted.

Under present laws, a person over 65 who retires with modest saving and a small pension, must live in fear of a serious illness, because it can wipe out those savings in a hurry. Only after they are gone can he apply for assistance in meeting his medical bills. But under a Social Security program, this same person would have no fear of financial disaster stemming from such an illness.

These are the people—retired people without medical insurance—who are not adequately provided for under present programs. And no referral service can answer their needs.

But beyond these considerations, we wonder about other effects of Congressman FINDLEY's referral service. Congressmen traditionally help constituents with personal business matters in the Nation's capital. This type of activity frequently takes as much or more of a legislator's time than does actual lawmaking. Adding to those duties the obligation to see that everyone in his district is getting adequate medical care could prove rather burdensome.

Furthermore, where does this type of thing stop. Might the logical next step be that the Congressman set up a referral service for persons who think their education is inadequate or those who consider their jobs inadequate.

Mr. Chairman, the editorial suggests that one reason for the referral service is to gather ammunition for the battle against medical care for the elderly financed under the social security program.

The primary purpose of the referral service is to serve my constituents. I freely confess that it is helpful as a means of gathering accurate information on the health needs of my district.

As a result of the referral service, for example, I drafted proposed improvements in the Kerr-Mills program proposals which were later embodied in the eldercare bill, which I introduced. In Illinois, at least, Kerr-Mills needs to be simplified, particularly as it relates to family responsibility. Eligibility standards are too complicated.

But this experience buttressed my confidence in the private system of medical care as it has developed in this country, and it has provided me with strong evi-

dence that, by and large, the health needs of my constituents are being met adequately.

This fact should not obscure the opportunities and responsibilities to make still further improvements, in our system of private enterprise medical care.

Unquestionably the United States has the best medical system in all the world, but it can be still better.

An effective nationwide referral service—operated through congressional offices—is one possible avenue for improving this great system. To be effective, it must be more than just an information service—important as information is. It must utilize the willingness—indeed the desire—of doctors and hospitals to render medical services without charge in those rare, exceptional, uninsured cases which do not fit any public assistance program.

Mr. HANSEN of Iowa. Mr. Chairman, history was made today. Few men have had the opportunity to participate in the performance of such a great and historic act as have those of us who are Members of the 89th Congress. I shall long remember having had this great privilege.

The Hospitalization and Medical Services Act passed today is a clear and positive answer on the part of our Great Society to the age-old biblical question put by Cain, "Am I my brother's keeper?"

This society—our society in these United States—is being fully responsive to the call for the provisions of this bill that have long been heard. The senior citizens of our country can now retain their dignity even though they may be required to undergo major hospitalization.

At long last the primary objections are a reality. We are following the example and reinstating into practice a principle which was set by our pioneer ancestors of three generations ago. Then it was common for three generations to be assembled in one family unit—a custom which provided care for the aged and housing for the elderly on a pay-as-you-go basis.

In our more complex society, care of the senior citizen was being pushed into the background. Coming from a State where the percentage of persons over 65 is the highest in the Nation, I am extremely pleased that we have recognized their individual worth and have protected their dignity through this legislation.

The leadership of the President in this positive legislation must not be overlooked. With his tremendous ability to clarify and his abundant energy to pursue the aims of the Great Society, he has helped in putting before the American people the needs and benefits of this progressive program.

I am proud to have been a part of this historic event.

Mr. MATSUNAGA. Mr. Chairman, I rise in support of H.R. 6675, one of the truly great pieces of welfare legislation since social security was enacted 30 years ago.

I do not intend to expound today, in the manner in which so many users of the U.S. mails have seen fit to write me

during the past several months, on the relative merits or demerits of this bill as compared with some alternative proposal.

Many of the authors of these communications show a regretful lack of accurate information on the medical programs being considered by this House. It appears that they were writing at the behest of another, and the views expressed did not represent the considered judgment of the writers.

Mr. Chairman, I should like to emphasize the need that is already well recognized, and to suggest that H.R. 6675 represents the best available plan, or the best combination of available plans, if you will, to fill that need.

We know, of course, that the problems our elderly citizens face in financing the cost of health care has become serious and widespread. We have repeatedly witnessed the tragic situation where older persons are reduced to a state of abject poverty after their modest life savings have been wiped out by serious illness. More damaging perhaps than the disappearing financial resources under such circumstances is the inevitable loss of self-reliance and self-respect.

If today's health cost is admitted to be a matter of serious consequence to the elderly, the question then comes to mind: Is it a problem of national concern?

Our Committee on Ways and Means has provided us with the answer. It estimates that approximately 19 million individuals would qualify on July 1, 1966, under the bill's basic plan which provides protection against the costs of hospital and related care. The problem is not localized in any one State or even any one region. It exists in my own State of Hawaii just as much as it is found in any area from Maine to Florida. Coupled with the national scope of this problem is the fact that the number of persons over 65 years of age is rapidly increasing and will reach an estimated 22 million by 1970. It is therefore a matter of great urgency that we provide suitable health care to Americans in this age group.

In selecting the medical program to fill this need, we should bear in mind a paramount consideration. And that is this, to extend to these citizens a medical program which is based on charity would, if I may use that well-known figure of speech, be pouring salt into an open wound.

There are of course many other factors to be considered. For example, the medical program which is adopted must be placed on a sound actuarial basis. Further, while flexibility from the standpoint of choice of medical coverage is to be desired, the plan must not be so loose in its application that it does little or nothing to meet the need for which it is intended. Finally, the selected plan must lend itself to universal application, that is, it must be administered with equal effectiveness irrespective of the size and geographical characteristics of a particular State. In short, it should do the work equally well in Hawaii as in California, New York, or any other State in the Union.

These admittedly are not easy criteria to meet. We know this. This August body has in this and prior years considered many proposed medical programs. Many contained objectionable features. Others were illusory in that they would have never filled the need. I submit that none has proposed to meet all of the requirements as well as H.R. 6675. The historic importance of this legislation has led us to study the bill at quite some length and in detail. I do not intend, therefore, to recapitulate its provisions. Our able chairman [Mr. MILLS] and members of his committee have accomplished that task beyond improvement.

Mr. Chairman, the opponents of this bill have alleged that its passage will have dire consequences upon members of the medical profession. After listening to the debate I am convinced that upon gaining an understanding of its provisions, the overwhelming majority of our doctors will approve this legislation.

Mr. Chairman, we are today writing an epic in American history. This piece of legislation will mark the boldest and most significant step the Congress has taken in insuring the health and happiness of ourselves and our posterity, for age we all must.

I urge a resounding defeat of the recomittal motion and an overwhelming vote to pass H.R. 6675.

Mr. GALLAGHER. Mr. Chairman, I am happy to give my full support to the medicare bill. Its passage by Congress will mean a happier and fuller life for millions of older Americans now and in the future. Approval of this bill was part of the great mandate which our people gave to President Johnson last November. And I don't need to remind you that passage of this bill was one of the great dreams of our late beloved President Kennedy. I have fought for such a measure for a number of years and was the sponsor of a similar bill to this one.

Someday in the future, Americans will look back on this moment as a great step, which can be compared to the adoption of the Social Security system itself. In this bill, we will establish a way that young people, in the prime of their working life, can set aside modest sums that will add up to better health and peace of mind in their older years. And so it should be. I don't know any American who wants a handout because he is old, unable to work and in poor health. This preserves his dignity and enables him to help pay his own way. As a result, the older man and woman in American society will be able to play a more respected and meaningful role. They are entitled to that respect and I am pleased that this bill helps to make it possible.

Mr. Chairman, this legislation is divided into four major parts. First, it provides a basic insurance program of hospital care. This will be financed in a manner similar to the regular social security system, by a tax on workers and employers. The program will provide up to 60 days of hospitalization and related nursing home service for all persons when they reach the age of 65.

The second part is voluntary. It covers doctor's fees in and out of the hospital. Aged persons who elect this coverage will pay a \$3 monthly premium which can be deducted from their social security cash benefits and this will be matched by a similar contribution from the Government. Hospital and medical benefits under these programs will be available beginning July 1, 1966.

The third major section of the bill calls for a 7-percent increase in social security monthly cash benefits. Under this provision, no primary beneficiary will get less than a \$4-a-month increase so all of the aged may purchase the optional medical program with no loss of income.

Finally, the bill makes many substantial improvements in the Kerr-Mills program for the poor and includes more liberal financing of health care services to needy children, the blind and the disabled. It also strengthens and expands the maternal, child health and crippled children's programs.

Mr. Speaker, the Nation will not be able to measure the effects of this bill in cold dollars and cents. How can you set a value on a happy, healthy life? During my lifetime, I have known many older citizens who have remained sick rather than ask for charity in the way of hospital care. Thank God, this will change that. It will remove most of the fears and dread of growing old alone with no one to care. It allows one to well meet the gathering years with dignity, with comfort, and confidence. Let us speed this bill to the President as fast as we can, so the Great Society can begin to take shape.

Mr. ROBISON. Mr. Chairman, I shall not take the time of the Committee to detail my position on this measure, because its pros and cons have been fully and ably presented and discussed here on this floor both today and on yesterday.

Beyond that, all of us other than the newcomers to Congress this year have, for several years now, had to wrestle with the serious and complex policy questions inherent in the action it now appears we are about to take. I am sure those policy questions—which in many ways are vastly more important than the mechanical details contained in the bill now finally before us—are well understood by all of us and by the general public to whom we bear the ultimate responsibility.

This measure contains much of which I wholly approve—much which, in the past, I have wholeheartedly endorsed—and, in several respects, encompasses certain legislative proposals I, myself, have made, either in this or in a prior Congress, in an effort to improve and to update our vastly important social security system which, by now, has developed into a keystone of our whole economic structure.

It is not necessary for me to detail that portion of the bill of which I approve, and which has my full support; I believe my position on these matters has been fully made known to my constituents and is understood by them.

In the same fashion, I am equally sure that my constituents have been made

fully aware of and understand my opposition—expressed so many times in the past—to the financing of any system of medicare or hospicare or any program involving service benefits as contrasted to cash benefits through resort to the payroll tax device which is, and has been, and should remain, in my judgment at least, free of any possible erosion as the future financial foundation on which the soundness of that basic social security system must continue to rest.

However, what seems about to happen here later on this afternoon will illustrate what all of us have surely known; that is, that any real consideration of such a viewpoint became as politically impossible as that position of opposition on my part became academic once the electorate had made their decisions in the presidential and congressional elections of last fall.

Those of us who have so been opposed to the adoption of the unfair and regressive payroll tax as the means for financing the broadened hospital care program now presented us—who have tried to point out to all who would listen the dimension of the future burden on the younger employees, particularly those just entering the labor force, and also on the self-employed person whose net earnings put him in the lower economic categories, that will thus be imposed—have done what we could to resist this decision.

We will make our last effort to prevent the seemingly inevitable conclusion to this longstanding debate, when the Republican recomittal motion is offered. I intend to support that motion and, even though the hour for decision is nearly upon us, I still urge all of you to give it your most serious and objective consideration, because I deeply believe it offers us the soundest and, as time will tell, the wisest method of financing "medicare" or whatever the program now proposed may properly be called. That Republican alternative also offers you a better—or perhaps I should say it offers the intended beneficiaries—a better and more comprehensive answer to the health needs of our senior citizens; I am confident that if you have given it the study this proposal deserves you will be inclined to agree that what I have said is so. The Republican proposal is particularly designed, as you will note, to meet that continuing problem—unsolved by the committee bill—of costly catastrophic illness, a problem which, if we do not meet it now, will come back to haunt us.

Let us talk figures for a minute. Under the committee bill an estimated burden of somewhere in excess of \$133 billion will be placed on that payroll taxing mechanism—a direct tax on the job-creating segment of our economy at a time when more and more businessmen and industrialists have had, in part as a result of foreign competition, to reluctantly consider automation as the answer to ever-increasing production costs. Surely there is a limit to what our economy can carry in the way of such a tax—and I must caution that we may be about to exceed that limit.

Surely, also, there is a limit to what we can ask a young worker, just entering the labor force, at, say age 21, to pay, not towards whatever future benefits he may hope to receive under the "medicare" part of this bill, but to finance similar benefits for those already retired or soon to retire; and, again, I must caution that we may be about to exceed that limit.

We have to ask ourselves about this, because the "prepayment" principle that we hear, time and time again, with respect to the committee bill's approach is an utter myth, since not only the basic social security trust fund but also the new, separate medical-care fund, will be operated on what amounts to an annual pay-as-you-go basis.

The net result of this is, then, that we are probably about to place a ceiling on the cash benefits now being paid or, in the future, to be paid to retirees and dependents under the basic social security system. I do not think we can, by recourse to this means of financing, go in both directions at once and, while this may indeed exert some sort of restraining influence on future improvements for medicare, it may well also have the effect of preventing our keeping that basic cash-benefit system in step with the inevitable toll of an inflationary economy until some alternative system for financing medicare is agreed upon—as some day I predict it will have to be.

In the meantime, however, I am today faced with a near intolerable decision. Under the closed or "gag" rule imposed upon us, those of us who are still flashing the red light of caution and concern for the dangers we see inherent in the decision about to be made, are required to weigh what we know is good in this bill—much of which, incidentally, has been put there by persistent Republican efforts to improve the bill before us—against that which we believe to be bad, and then to vote the bill "up" or "down."

As I have said, I endorse and support and will vote for the Republican recomittal motion. I hope that motion will carry and, as of this moment, I believe it has a chance.

However, fully recognizing that there is a very real, unsolved problem with respect to the health-care needs of our senior citizens—which problem has not yet been solved—and fully recognizing the need for action, now, on those other portions of this bill, the benefits of which could have been made available to those in need thereof last year except for the political decisions that were made, I will, with reluctance and with considerable reservations, nevertheless vote for this bill even if the Republican alternative is refused.

I shall do this with and in the hope that this Congress—or perhaps the next Congress, as seems more likely—will continue to give this matter the continuing study it urgently requires, and will correct the fundamental mistake I believe we are making by enacting a compulsory health-insurance program financed by a regressive and discriminatory payroll tax.

Mr. DOLE. Mr. Chairman, as debate on H.R. 6675 draws to a close it is apparent that the real opposition to the bill stems from the fact hospitalization benefits are to be financed by a compulsory payroll tax administered by the Social Security Administration.

It is obvious the great majority of Members, Republican and Democrat, would support H.R. 6675 if it were not for this feature. To support this statement I remind my colleagues of the action taken by this body July 29, 1964, on H.R. 11865.

The principal provisions of that bill—H.R. 11865—as taken verbatim from the committee report were as follows:

A. FIVE PERCENT ACROSS-THE-BOARD INCREASE IN INSURANCE BENEFIT PAYMENTS

The bill would increase the insurance benefit payments under present law by 5 percent for all persons now on the benefit rolls and for all future beneficiaries.

1. Workers', dependents', and survivors' benefits

For workers retiring at age 65 with average monthly earnings of \$400 or less, monthly payments would range from \$42 to \$133.40 for primary beneficiaries as compared with \$40 to \$127 under present law. Primary benefits ranging up to \$143.40 would be payable to people who retire and come on the benefit rolls in the future as the increase in the earnings base that the committee is recommending makes possible the counting of up to \$5,400 of annual earnings toward benefits along with the 5-percent increase in payments. Survivors' and dependents' benefits would also be proportionately increased.

2. Family benefits

Under present law, the ceiling on the total amount of family benefits payable on a worker's earnings record ranges from \$60 to \$254 a month, depending on the worker's average monthly earnings. Under the bill the minimum amount of monthly benefits for a family would be raised to \$63 and the maximum would be \$281.20 at the \$400 average monthly earnings level, which is the highest possible under the present \$4,800 earnings base. In the future, maximum family benefit amounts up to \$300 would be payable as the \$5,400 earnings base that the bill would provide becomes effective and average monthly earnings rise above \$400.

3. Number of beneficiaries and effective date

The 5-percent across-the-board increase would be effective for the 20 million beneficiaries on the rolls in their benefit payments which are due for the second calendar month following the date of enactment.

For the first full year, 1965, it is estimated that \$925 million in additional benefit amounts would be paid as a result of this 5-percent increase.

B. PAYMENT OF BENEFITS TO CERTAIN AGED PERSONS

The bill would provide limited benefits for certain aged individuals who have some social security coverage but not enough to meet the minimum required by existing law.

A special provision would liberalize the eligibility requirements so that certain aged people who do not meet the work requirements in present law could qualify for benefits on the basis of as few as three quarters of coverage. Upon attaining age 72, a worker or widow who qualifies under these provisions would get a monthly benefit of \$35; a wife who qualifies would get a benefit of \$17.50.

C. PAYMENT OF CHILD'S INSURANCE BENEFITS TO CHILDREN ATTENDING SCHOOL OR COLLEGE AFTER ATTAINMENT OF AGE 18 AND UP TO AGE 22

The bill would provide for the payment of child's insurance benefits until the child reaches age 22, provided the child is attending school, including a vocational school, or college as a full-time student after he reaches age 18.

This provision would become effective for the month following the month of enactment, or September 1964—whichever is later. It is estimated that 275,000 children will benefit in the total amount of \$175 million under this provision in 1965.

D. BENEFITS FOR WIDOWS AT AGE 60

The bill would provide for the payment of benefits to widows beginning at age 60 at their election, with the benefits payable to those who claim them before age 62 actuarially reduced to take account of the longer period over which they will be paid. (Under present law widow's benefits are payable at age 62.)

This provision would be effective for months after the month of enactment. In the first full year, 1965, it is estimated that 180,000 widows will take advantage of this provision and receive \$150 million in benefits.

Mr. Chairman, the vote on final passage in favor of the measure was an overwhelming 388 to 8. This bill could have been enacted last year if the administration had not insisted on additional provisions financed by a regressive payroll tax. The point is that nearly everyone supports the concept that adequate medical protection should be made available to the aged but it should be voluntary and should reflect ability to pay.

In conclusion let me restate my support for those provisions embodied in H.R. 11865 last year and now contained in H.R. 6675. Let me also state that it is unfortunate that the provisions in H.R. 6675 relating to compulsory hospitalization under social security will compel many of us to vote against the measure. This one provision poses an enormous threat to the cash benefit programs under the social security system by imposing upon that system a liability to finance undetermined future service benefits. Therefore, in my opinion, this bad feature necessarily outweighs the beneficial provisions.

Mr. HATHAWAY. Mr. Chairman, the bill before the House today marks an historic milestone, as many have noted, on America's journey to fulfill the pledge in the Preamble to our Constitution to "promote the general welfare."

As the wealth of our Nation increases, we have established the humanitarian principle of using some of that great wealth for the betterment of all our citizens. The medicare bill which we will soon enact into law enables all American citizens to hold their heads higher, to speak proudly of our commitment to our senior citizens.

I have the privilege of representing part of the State of Maine here in Washington. This legislation is particularly important to my State because of the nature of our population.

Whereas only 9 percent of this country's population is 65 years of age or older, we in Maine have 11 percent of our citizens enjoying those golden years. And while 13 percent of the Nation is 60

years of age or older, Maine boasts 15 percent of her population in that group.

The medicare bill will mean added peace of mind and a more secure life to all of the almost 110,000 people in Maine who are 65 years of age or older. Whether or not these people are now receiving social security, this bill will let them participate in the basic hospital program. And each of these people will also have the option of enrolling in the additional, supplementary voluntary insurance program, covering doctors' bills and other items.

I believe special commendations are in order to the members of the House Ways and Means Committee. Their study of the bill was one of the most thorough ever undertaken in the House. The broader bill which emerged from that committee reflects the deep concern of the members for all the medical and economic problems which have plagued the senior members of our country.

I am pleased to be a Member of the Congress which is today making history. I am happy to help fulfill one of the President's pledges. I believe the confidence expressed by the people of Maine in their overwhelming support for the President last November has been justified.

Mr. ANDERSON of Illinois. Mr. Chairman, I firmly believe that it is most unfortunate that we are being called upon to vote up or down with one vote and to be denied the parliamentary opportunity to make the social security bill before us into a better bill. Indeed, I do sincerely believe it is most unfortunate that while this bill contains features which are essentially good and recommendations that I have made myself over the years, that each member of this body is being asked to decide with a single vote either to accept provisions in this bill which he finds objectionable or to reject those provisions which are highly meritorious and which he favors.

I voted for all the benefits that passed the House last year such as the provisions to increase monthly benefit payments to our social security retirees by 7 percent across the board with a \$4 minimum increase for each retiree, providing tax exemption for certain religious groups, to continue benefits for certain children in school to age 22, provide actuarially reduced benefits for widows at age 60, provide benefits on a transitional basis to certain persons currently 72 or over who are now ineligible, liberalize the definition for disability insurance which in many instances the Social Security Administration presently interprets in a manner that is contrary to the intent of the original enactment of this provision in the law, as well as modifying the earnings limitation to increase the amount an individual can earn without suffering full deductions from his monthly social security benefits.

These social security amendments were agreed upon by the confidence committee in the 88th Congress. They should have been enacted into law last year. They would have been had it not been for the fact that the administration wanted to withhold those advantages of this bill purely and simply as a bargaining device like the frosting on a cake in

order to force the membership of this body into accepting the ill-advised concept of using a regressive payroll tax for a hospital room and board program which many of our 18 million senior citizens over 65 were led to believe at that time was the answer to all of the medical care problems.

However, largely because of Republican efforts in the House, who were concerned about the more than 25 percent of the medical health care costs that the administration's compulsory program would only pay by way of room and board in a hospital, I am pleased to see in the bill the Republican recommendations for a voluntary supplementary health insurance plan providing for physicians' and other medical and health services that would be financed through small monthly premiums by individual participants. These individual payments would be matched equally by a Federal contribution from the general revenues in the Treasury.

I am also glad to see Kerr-Mills Act improvements in the bill which will enable our State of Illinois to improve its already extensive Kerr-Mills program.

However, I am terribly disappointed that the committee bill falls far short of the Republican bill in far too many important respects. While the Republican bill would provide far more benefits than the committee bill, it would do so with joint contributions from individual participants who would pay only a nominal fee with the balance paid for out of general revenues in the Treasury. The Republican bill would not use a regressive payroll tax. It would not jeopardize future increases in cash benefits, which the committee threatens to do. The hospitalization program in the committee bill imposes a \$133 billion liability on the social security tax structure.

Amazingly enough, the committee bill fails to provide for catastrophic illness, the largest single factor which might be used to justify a program of subsidized medical care for those over 65 and which concern has been reflected in some of the letters that I have received on the subject. The Republican bill on the other hand would provide for catastrophic illness to the extent of a lifetime maximum of \$40,000.

The committee bill excludes prescribed drugs while the Republican bill would pay for them.

Duplication of coverage envisioned by the committee bill will not provide the best protection for the least dollars. It will needlessly force duplication of coverage for those over 65 who are already adequately covered at no cost to themselves under adequate programs of group health insurance, provided by their employers, their unions or by other organizations. These people have no need for a government program.

There is no deterrent in the committee bill to excessive utilization of benefits on the part of those enrolled.

Further, the committee bill gives false rise to the concept of entitlement by creating the erroneous impression that a wage earner is prepaying for his hospital benefits. A participating individual will pay for 44 years in advance for benefits

afforded to those already 65 and those reaching 65 before him.

When you consider what the committee bill is going to impose on every wage earner in the way of a tax and project this from age 21 to the time such an individual reaches age 65, it is shocking to find that the total social security tax on wage earners is going to rise to the unbelievable height of 11.2 percent. If this same wage earner were to keep these funds and invest them at an interest rate of 4 percent, compounded semi-annually, which incidentally is today's prevailing interest rate, this employee's contribution forcibly taken from him by the provisions of the committee bill will amount to the fantastic sum of \$81,000.

Indeed, Mr. Chairman, there are many inherent advantages in the Republican proposal that make it far superior and less costly than the committee bill. By eliminating duplication of coverage and combining all medical benefits in a single comprehensive insurance program, the Republican program will provide more protection for less dollars.

The Republican proposal would eliminate need as a basis for qualification without extending benefits to those who are able to pay the full cost of their own insurance. It would do this by providing for premium contributions related to cash benefits under social security, coupled with a tax recoupment of the subsidy to individuals with incomes over \$5,000.

When you take note of the foregoing observations that I have made, I am confident that one would have to conclude that the Republican program of voluntary medical health insurance is vastly superior to the one envisioned by the committee bill.

In my remarks, I must in all justice commend the committee for the other amendments that it saw fit to incorporate into this bill. With the exception of the shortcomings some of which I have enunciated beforehand, I think the committee has done an admirable job. In other words, I would commend the committee for coming up with a bill with the exception of the compulsory payroll deduction portion, and perfectly frankly admit that with the exception that I have noted, the bill has broad support among Democrats and Republicans alike.

Mr. Chairman, it is obvious I think from what I have already said that many Members of this body will face a difficult decision with respect to what they should do if the motion to recommit does not prevail. I sincerely hope that the motion to recommit will receive the support of a majority of this House. For as I have already indicated it would bring to the American people a vastly superior bill, free of all of the inherent dangers which lie beneath the surface of the administration bill like so many submerged icebergs.

Mr. Chairman, if the motion to recommit does not prevail, I cannot in good conscience vote for the final passage of the administration bill. I cannot thereby put my stamp of approval on what is essentially a blackmailing tactic to literally force Members of this House to swallow unsound and dangerous pro-

visions along with those which are not controversial. The administration bill reminds me of a line from the popular song: "A Spoonful of Sugar Makes the Medicine Go Down."

Mr. Chairman, this is precisely why I voted in the Committee on Rules for an open rule. I did not want to see this House driven to make the kind of decision it is being forced to make today. I have always supported our social security system insofar as its cash benefit provisions are concerned. Indeed, as I have already pointed out, last year I voted to extend and improve the cash benefits paid under that system. I would so vote today if that were the sole issue before us. However, with the transmutation of our social security system from one which pays cash benefits to one which is now going to provide medical services we are witnessing merely the first step not only toward the ultimate socialization of the medical profession but the first step toward what may be the eventual wrecking of an otherwise soundly conceived social security system. I certainly cannot in good conscience, with so much at stake, give my vote of approval to any such ruinous course of conduct.

Mr. CLEVELANDER. Mr. Chairman, the 89th Congress will be remembered, I am sure, for many fine accomplishments. It is gratifying to me individually and as a Representative from the 11th District of Michigan to have been able to cast my vote along with my colleagues for the bold and new programs being put together here to insure that all of our people have an opportunity to participate in the growth and vitality of this Nation. I look on our action on medicare as one of the most significant of this Congress.

The passage of medicare will climax a long struggle on behalf of our senior citizens for a program which will help them provide for themselves adequate health care in their declining years.

Under this measure, we have moved to ease the burdens of retirement, to end the fear of a life's savings vanishing overnight as a result of serious or prolonged illness. This program is equally important to our younger families who often have had to make heavy sacrifices in order to carry the burden of health care for aged parents.

This program is going to mean a great deal, not only to the more than 45,000 of our senior citizens in the 11th District of Michigan, but to all our citizens in the 11th District, in the State of Michigan, and in the United States.

We have many serious economic problems in the 11th District of Michigan, not the least of which is adequate health care for our older citizens. The right of our older citizens to dignity in their declining years under the assurance that they will have shelter over their heads and adequate food and clothing was established firmly with the adoption of the social security system.

At that time, many of the arguments we have heard in the last few years about medicare were used to raise the fear that social security would not work; that it would be too expensive; that it would

turn us into a nation of sheep dependent on an all-powerful master in the form of the Federal Government. This was not the case as the history of the social security program has demonstrated.

The medicare program, in my opinion, adds a new dimension to the principle involved in our social security program. It is the dimension of insuring during our working years that we will have protection against devastating onslaughts of illness in our retirement years. It has been made clear in the debate—and I want to emphasize it again—that this medicare program is a pay-as-you-go program; it is not charity. It is an insurance program under which all of us will contribute from our earnings to make sure that we can meet the health problems of our old age.

I am pleased to note at the same time the proposed increase of 7 percent in social security benefits which accompanies this bill. This increase in benefits is certainly in tune with the needs of our retirees and the economic reality of the times.

I am sure this increase will make it possible for many of our older citizens to take advantage of the optional part of the medicare program which will provide insurance coverage for up to 80 percent of doctors' bills for a small monthly premium.

Mr. GROVER. Mr. Chairman, we have taken up in 2 days of intensive debate one of the most controversial legislative programs of recent years in H.R. 6675, the so-called medicare bill.

There can be no question about the needs of many of our senior citizens. Inflation, high taxes, competitive employment markets, and a variety of factors have caused severe economic hardship to settle on many. I have seen the severe financial impact of catastrophic illness on these people.

I have in the past and still do find the Kerr-Mills approach an excellent one, although I am realistic enough to know and admit that Kerr-Mills has not been used in many of our States where many aged indigents reside and suffer without proper medical and hospital care.

I believe the eldercare and the Byrnes approach, with their noncompulsory features, their broader coverage and means test are preferable to the social security vehicle, which is a regressive approach, one which burdens the low- and middle-income wage earners.

Thus, in supporting this revised omnibus bill, I am looking affirmatively to the noncompulsory medical coverage and to a much-needed increase in benefits and earnings limitation, but with cautious reservation on the social security approach.

And so, Mr. Chairman, I caution the Congress and urge the Ways and Means Committee and other appropriate committees to screen and study the application and progress of this legislation to the end that its shortcomings can be corrected and the program improved to protect hospital and medical care recipients and to protect the medical profession from the deterioration which the

profession has experienced in other countries where government interference and control was excessive.

We must constantly review from the actuarial point of view the vague and gray areas which some have referred to in the funding of our social security system.

We have come a long way since the 1930's, when the social security system in this country was conceived and implemented. It has had its critics over the years, but few are heard who would abolish it. It has become a part of the American scene. But something must come from something. I feel this new program goes as far—and we hope not too far—as a sound funded system could possibly go.

I am sure that all of my colleagues who express this reservation hope with me that our fears of instability will never be realized.

Mr. SCHEUER. Mr. Chairman, today we are finally within sight of an achievement so important, that if the 89th Congress did nothing more than enact the medicare program, it would be remembered in American history as one of the greatest Congresses ever to convene in Washington.

Exactly 30 years ago the monumental social security program became law. Its highly organized and vocal opponents accused President Roosevelt of fascism and communism, freely predicted the end of private enterprise, individual initiative, and the American way of life, and promised its repeal.

Social security has of course proved to be one of the most enduring and popular laws ever passed in this Nation. Today no candidate anywhere on the political spectrum would seriously urge its abandonment. Social security, far from ending the American way of life, has become the American way of life itself—a way of life which says to the world that ours is a generous and humane society which values and respects human dignity.

The 89th Congress is now on the point of dramatically reaffirming these values by enacting a program of medical insurance for the aged which will rival social security itself as an example of the greatness and compassion of the American society.

THE SOARING SPIRAL OF MEDICAL COSTS

The cost of medical care is the fastest rising cost of any component of the Consumer Price Index. Hospital care has been, by far, the most rapidly advancing element of medical care costs. In the 14-year period, 1950–1964, medical care costs increased 63 percent; hospital daily service charges over the period increased 150 percent. In contrast, the total Consumer Price Index rose during this period by less than 30 percent.

The average daily cost of hospital care is nearly \$40, and according to the American Hospital Association, we can expect an annual increase of about 5 percent during the next 5 years.

The spiraling movement in medical costs is only partially due to inflation. It also reflects the improved quality of medical care—the myriad new lifesaving drugs, techniques, and procedures.

These developments do not, and cannot, come cheaply.

THE FLIGHT OF THE AGED

More than any other segment of our society, the aged have borne the brunt and burden of skyrocketing costs of medical care. A few simple statistics make this clear beyond doubt:

Half of aged couples have total incomes of less than \$2,600 annually.

Half of aged persons living alone have incomes of less than \$1,100 annually.

About half of aged family units have liquid assets of less than \$1,000: Many have none.

One in six of the aged is hospitalized each year.

Nine out of ten older persons are hospitalized at least once after age 65.

About half the aged have no hospital insurance. Available coverage is either woefully inadequate or costs more than the older person can afford to pay.

One-third of families considered poor are headed by a person above the age of 65. Nine out of ten couples, with at least one member 65 years or more and receiving no public welfare nor help from private voluntary agencies, had medical costs that averaged \$442 in 1962. One out of four of the couples had at least one member hospitalized in 1962 and the average medical cost of these one out of four couples was \$1,200. Couples with no hospitalized member during the year had medical costs of \$233, on the average. Unmarried aged persons had a median income of \$1,180, and spent \$1,000 for an average hospital stay.

In short, millions of our elderly citizens have been paying the equivalent of 50 to almost 100 percent of their annual incomes on medical expenses. These figures clearly tell the inhuman story of staggering debt and physical deprivation on the part of our senior citizens that has increasingly been a dark blot on America's conscience.

Furthermore, there is no way of being certain how many of our aged have died because they were simply unable to avail themselves of the excellent American medical care which is available to more fortunate Americans. One study in Michigan found that 45 percent of the people with incomes of less than \$1,000 had one or more untreated symptoms. Only 10 percent of people with family incomes of \$5,000 and over, had untreated symptoms. A Boston study showed that twice as many of the poor over 65 had untreated symptoms as the well-to-do over 65.

A VICTORY IN THE WAR AGAINST POVERTY

Probably the strongest evidence of the need to help the aged meet their medical requirements was given by Secretary of Health, Education, and Welfare Celebrezze in his testimony at the executive hearings of the Ways and Means Committee on Medicare:

Some three-fifths of the aged going on public assistance—old age (OAA) and medical assistance for the aged (MAA) together—do so because of health costs. Today over one-third of all public assistance expenditures for the aged are for health costs.

What Secretary Celebrezze's statement means is that most of our aged citizens

would be able to support themselves in dignity, independence, self-respect, and security, if it were not for the single devastating factor of serious illness, and the unbudgetable cost of medical care.

Thus, the medicare program, in the broadest sense, can be considered a great victory in the war against poverty. For it is clear that it will prevent poverty for millions of Americans, and relieve them of the indignities of asking for public assistance after a lifetime of productive labor, and independence.

OPPOSITION DIES HARD

Mr. Chairman, in spite of these undisputed facts, the opposition to medicare over the past several years has been highly organized, unremitting, and until this moment, all too successful.

The American Medical Association has been almost universally criticized for its continuing scare campaign against health insurance under social security. It is an old story, and I will not once more detail the AMA's sorry record of irresponsible opposition.

It is important, however, to see this opposition in historical perspective. For the truth is that the American Medical Association has opposed virtually every hard-earned inch of progress in social welfare for the past three decades. Its opposition to medicare is as bankrupt as its opposition to social security 30 years ago, when it called that program "the first step in the breakdown of American democracy."

This powerful organization has done untold damage to the prospects of the medicare program in past years. Today, as we are near victory, we can perhaps afford a measure of magnanimity in our view of the AMA. But surely in the eyes of the vast majority of Americans its long record of unrealistic nay-saying has lost it any legitimate claim to determine the means and techniques of disturbing medical services in this country.

OVERWHELMING APPROVAL HOPED FOR

Mr. Chairman, it is my hope that this body will speedily give H.R. 6675—the medicare program—its overwhelming approval. After years of hope deferred, the aged citizens of this country have a right to feel that the Congress is finally heeding their needs.

I firmly support this program, and it is overwhelmingly supported by my constituency. I am particularly gratified that the bill finally covers those whose incomes include cash tips. This corrects the gross injustice suffered by retired persons who in their working years relied heavily on tips for their income—income on which they paid Federal taxes. Covering tips in social security would benefit a million employees and their dependents. These employees are estimated to receive over \$1 billion in tips each year.

ONE UNFORTUNATE EXCEPTION

The bill as it stands, with its combination of basic compulsory coverage of the costs of hospital and home care, and additional voluntary coverage to cover physicians' fees—a combination which is a stroke of genius—is a better and stronger piece of legislation than its proponents could have dared hope for even a year ago.

It has one important deficiency, however, which the Congress would do well to correct. H.R. 6675 would exclude from payment under the basic hospital program, the services of radiologists, pathologists, psychiatrists, and anesthesiologists even if they are employees of the hospital or, by arrangement, have the hospital collect their fees for them.

The services of these specialists are often included as a routine hospital expense, a practice which H.R. 6675 as it now stands will surely kill.

The American Hospital Association does not want a change in present practices. It has been estimated that the services of these specialists account for a fifth or more of the hospital bill.

It is very likely that these specialists' fees will rise considerably once they are no longer collected by the hospitals with which they are associated. If H.R. 6675 is not amended to remove the exclusion, the aged who do not participate in the voluntary medical plan will have to bear these charges themselves. And to the extent that the voluntary insurance is subscribed to, the Federal Government will be made to bear the burden of increased fees.

I therefore urge the Congress to amend H.R. 6675 to cover the services of these hospital specialists under the basic hospital insurance plan as outlined in the bill.

In an historic test case, the Supreme Court of the United States upheld the Social Security Act of 1935 with these stirring words, written by Justice Cardozo. The hope behind the act, he wrote, was "to save men and women from the rigors of the poorhouse as well as from the haunting fear that such a lot awaits them when journey's end is near."

Mr. Chairman, the same simple human hope inspires the medicare program of 1965. That hope must be fulfilled.

Mr. HUOT. Mr. Chairman, I rise in support of H.R. 6675, which I consider one of the most important and needed bills to come before the Congress in this decade.

I would also like to take this opportunity to commend all the members of the House Ways and Means Committee for their recommendations that a basic plan and a voluntary supplementary plan be established. I believe this bill meets the objections of some who say that the hospitalization plan was insufficient to meet the needs of our senior citizens.

This bill is needed, and in testimony I would like to submit a brief argument regarding the State of New Hampshire and what I consider its urgent need for this legislation.

New Hampshire has a population of a little over 600,000. By 1970 it is projected that those over the age of 65 will number over 85,000. As can be seen by these figures there is a high population of elderly in New Hampshire.

There are no adequate statistics developed concerning the average income of persons over 65 in my State. A national study completed in 1963 on the basis of a sampling revealed the following median annual income for persons over 65: married couples, \$2,875; non-married men, \$1,365; nonmarried women, \$1,015. It was found that al-

most 3 in every 10 couples had less than \$2,000 yearly income.

Everywhere in this country the costs of hospital care and nursing home care are rapidly rising. Without this legislation, Mr. Chairman, the earnings and savings of a large percentage of our population may be wiped out with just a month of illness requiring a stay in a hospital and convalescence in a nursing home.

The basic plan under H.R. 6675 will meet these problems which so many of our senior citizens face today. The average premium of about \$19 a year which will be paid during their working years is indeed cheap enough for the sweeping benefits they will receive when they attain the age of 65 when these benefits are really needed.

The voluntary supplementary plan enables the person 65 or over to add to these benefits if he feels his income is sufficient to pay the \$3 monthly premiums.

The other sections of this bill, I believe, strengthen the existing Federal and State obligations to the welfare of the American people.

After careful consideration it is my opinion that this legislation does not affect the doctor-patient relationship necessary to maintain high quality medical care for our senior citizens.

The society in which we live has offered much in the way of a better life for all. We are a prosperous Nation and a country which is fulfilling its obligation to provide for the common welfare.

With a high percentage of elderly whose median annual income is less than \$2,000, New Hampshire's senior citizens have gone on record in favor of this legislation.

Mr. Chairman, I urge the Members of the House to join me in voting for H.R. 6675.

Mr. DERWINSKI. Mr. Chairman, it is often said that "a politician is a man who thinks of the next election while a statesman is one who thinks of the next generation." In voting against final passage of this measure, I am taking what I believe to be a statesmanlike position, with the long-term interests of the public in mind, rather than the politically motivated position of the administration which is propelling the bill through the House with a minimum of debate and review.

The increases in the social security tax found in this bill will impose a constant drain on all American wage earners. We witness in this bill the fantastic development by which a person supporting an average-size family and drawing an average national wage will be paying a larger social security tax than personal income tax.

As we look into the future, we see clear signs of rigid governmental control of our medical system which can only be detrimental to all our citizens. At the risk of oversimplification, may I state that this bill is a sugar-coated pill that is being swallowed in an easy fashion, but its ill effects will be felt in the ultimate crippling of our medical services and unwarranted, regressive tax burden on our citizens.

It is especially tragic that alternative proposals which would have used free enterprise insurance coverage and would have provided legitimate coverage for older citizens truly in need have been arbitrarily rejected by this politically motivated administration.

Mr. Chairman, as part of my remarks I include a letter from a constituent which very effectively states the citizen's point of view on this subject:

CHICAGO HEIGHTS, ILL.,
April 5, 1965.

HON. EDWARD J. DERWINSKI,
House of Representatives,
Washington, D.C.

DEAR MR. DERWINSKI: As my Representative in Congress, I urge you, sir, to vote against the King-Anderson bill (H.R. 1) currently before the 89th Congress, commonly referred to as medicare, for the following reasons:

1. Social security benefits and the corresponding taxes are already reaching the saturation point, as far as the middle-income taxpayer is concerned. With tax increases already scheduled for social security under present law of 8.25 percent on \$4,800 of income as of January 1, 1966, or \$198 per year on each employee and employer, and with additional taxes (9.6 percent on \$5,400 of income) and increased benefits contemplated under the existing social security system, I for one, Mr. DERWINSKI, do not want to pay another \$16.80 per year for medicare. If all these increased welfare taxes go through, social security taxes will be pushed above 10 percent, but will this be the end of it? More importantly, can the existing social security system stand the additional load of medicare benefits? As you know only too well, this is only the beginning of an insatiable drain on the Federal Treasury, if the recent experiences of France, Italy, and other Western European countries with health care for the aged are any reliable indication.

2. Medicare does not permit; it compels every wage earner to participate in the plan. The wage earner is taxed; he does not contribute.

3. Medicare would call for higher payroll taxes on all wage earners to pay for benefits for everyone over age 65, the rich and well to do as well as the needy. Contrary to the current Democratic administration's pronouncements, the elderly of this country are quite well off. I'm sure that you are aware that on the average the net worth of the family whose head is at least age 65 is \$30,718, considerably higher than the average net worth for most younger family age groups. Moreover, current statistics tell us that 80 percent of 65-plus families own their own home free of any mortgage, and 82 percent of elderly families owe no installment debt. Only one-third of the total income of Americans over age 65 (\$35 billion) comes from social security and other Government retirement programs.

In view of the above, Mr. DERWINSKI, is it morally right or fiscally sound to tax the younger wage earner to pay for the hospital bills for older people who, in the main, can afford to pay their own bills? I for one am trying to create or accumulate moneys for my later years, to buy a home, and to send my children to college, and I do not think it is morally right to have young workers pay medicare taxes during their wage earning years to pay the heavy medical costs of today's beneficiaries. Of course, tomorrow's benefits would have to be paid by tomorrow's taxpayers—my children. My children are already going to have to pay for my social security pension out of their taxes, why add my medical bills?

4. Current surveys show that 96 percent of the elderly people over age 65 do not owe

any money to a doctor, a dentist, or a hospital, and 60 percent of the elderly already have protected themselves against the cost of illness through health insurance and other prepayment plans.

5. Medicare hits those least able to pay—people like myself, for example. The \$5,600-a-year worker would be forced to pay as much tax as the \$56,000-a-year executive.

6. Medicare in its present form, although I understand Mr. WILBUR MILLS' House Ways and Means Committee has recently rectified this to some extent, does not provide anything for the following: doctors' bills, surgeons' fees, bills for drugs, medicine, medical appliances, dentures, eyeglasses, and hearing aids. Medicare would provide only for hospitalization care on an inpatient basis and some nursing home care for 60 days maximum after discharge from the hospital.

7. Medicare if passed would permit the Federal Government to exercise an undesirable degree of direct control over hospitals and doctors. Free choice of hospital, nursing home, and physician would be impossible under medicare in most cases. If a hospital chosen by the patient was not participating under the medicare plan, the patient would have to go elsewhere. If the patient's personal physician was not on the staff of a participating hospital, the elderly patient would have to accept another doctor.

8. Finally, and perhaps most important of all, I don't think that the majority of the people in this country fully understand this vital issue. According to a recent Gallup poll published in the Nation's newspapers on January 4, 1965, 77 percent of the American people do not fully understand the provisions and limitations of the medicare tax plan. Does this indicate a mandate to the current administration to pass this bill, when 150 million people don't know what they are getting? Is this democracy in action?

What am I for? I am for, and I urge you to support, either the Herlong-Curtis eldercare bill (H.R. 3727) or the proposal introduced by Representative JOHN W. BYRNES, Republican, of Wisconsin. I say either bill because I think either of these bills would go a long way toward rectifying the many ills of the King-Anderson medicare bill listed above, and in addition both the eldercare bill and the Byrnes proposal would utilize Blue Cross, Blue Shield, and other private health insurance companies, who are experienced administrators and operators in this field.

I thank you, Mr. DERWINSKI, for giving this letter whatever attention you could, and I urge you, again, to vote against medicare.

I am,

Very truly yours,

JOHN R. GLENDINNING.

Mr. HARVEY of Indiana. Mr. Chairman, although I stand opposed to H.R. 6675, the administration's medicare bill, I would like to point out that this does not mean that I am unmindful of the problems that prompted this legislation in the first place. Rather, my concern is with how best these problems can be solved. Through compulsory payroll tax deductions for everybody under social security, the authors of "medicare" say that the public interest will best be served. I cannot agree with this. The Republican alternative actually offers a more comprehensive program of medical insurance, financed partly by premium contributions, and by the general revenue tax system based on ability to pay.

Under the provisions of King-Anderson all people 65 and over would be eligible

for benefits. The Republican program is voluntary, thereby reducing appreciably the costly duplication of coverage. The King-Anderson measure takes everyone 65 and over and makes them "wards of the state" insofar as hospital benefits are concerned. To me this is not only an insult to the American people, but lacking in understanding. The senior citizens of this country want to be independent and, above all else, they do not want to be a burden on the working men and women of this Nation. The proposal offered by the Republican leadership will enable these people to make small contributions, which they themselves are willing to do to keep their independent status.

Pollsters have stated that over three-fourths of the total civilian population and 60 percent of the aged population, had some form of private health insurance as of December 31, 1962; and that there is reason to predict that senior citizen's participation in private health insurance programs will increase appreciably in the years ahead. It would seem to me that King-Anderson goes too far. Actuarial experts have projected that a young man entering the work force will have paid into the social security fund a staggering amount of money by the time he reaches 65. Had this money been invested privately and interest accrued the total figure is slightly over \$38,000—hardly an insignificant sum. Insurance companies in the United States have stated a willingness to offer more comprehensive coverage for less cost. While it is true that the administration's bill does have a voluntary enrollment provision whereby for a small monthly premium doctor's and related services will be paid, the Republican proposal, at no extra charge, covers cases of a catastrophic nature as well as doctor's fees and drugs. Last but certainly not least, among my objections are the cost estimates of the program under social security.

I do not believe that even the experts actually know just how much this program is going to cost the American taxpayers. Having recognized the importance and need for constructive legislation in this field, in January of this year I reintroduced a bill to provide a completely voluntary medical care insurance program. I introduced similar proposals in the 87th and 88th Congresses. It does not require action by State legislatures. It contains no "means test." It is based upon a completely confidential relationship between each individual and the Treasury Department, the health insurance carrier of choice, the doctor, and the hospital. It does not discriminate. It is a true free-enterprise plan to help Americans take care of themselves.

Under the provisions of the Harvey bill every American who is 65 or over would file a Federal income tax return whether or not he owed any tax. A simple, easy-to-file return is recommended. If an individual or a married couple owed no tax, the Treasury Department would give a medical care insurance certificate.

The certificate could be used to obtain the kind of medical care insurance the citizen desired. The insurance carrier, in turn, would receive payment of the premium cost, up to \$150 per person, by presenting the certificate to the Treasury.

Also in this regard I think it is noteworthy to mention that there is a growing trend in the United States toward the purchase of health insurance for retired employees by former employers. The Harvey bill encourages this practice by offering the same \$150 credit to the employer who provides health insurance for retired employees. As of March 1965, 40 States and 4 Territories have initiated the legislative authority for implementation of the Kerr-Mills program of medical assistance for the aged who are recipients of old-age assistance. My proposal is intended as a supplement to the Kerr-Mills law and other programs which assist in medical care for senior citizens. To a great degree, the provisions in the Harvey measure would replace the other programs. There would be approximately 14.5 million Americans over 65 who would be eligible for benefits. Maximum possible cost of the program would be 14.5 million multiplied by \$150. This figure would be reduced somewhat by several factors, including: (1) the amount spent by the Government under other programs would be reduced appreciably, and (2) there would be a displacement of most income tax deductions now claimed for illnesses. First full-year cost estimates under King-Anderson are \$2.3 billion. Under the Harvey bill, first full-year cost estimates predict \$1¼ billion. This amount, however, would not appear as an additional appropriation but rather as a reduction in the general revenue. By comparison of the two programs and the effect the King-Anderson bill will have on the economy and the social security programs, I invite my colleagues to join me in opposing this ill-conceived legislation.

Mr. FRASER. Mr. Chairman, the bill we are considering today, H.R. 6675, is the most significant legislation to improve the quality of living for retired Americans since the enactment of the social security law.

I have supported the principle of providing hospital insurance for the elderly under social security since I was first elected to Congress. In both of my election campaigns I stressed the importance of enacting the King-Anderson medicare bill. I believe that the people of my district strongly support medicare.

In its consideration of the proposals on health care for the aged, the Ways and Means Committee wisely rejected proposals which would have us rely solely on welfare programs. Welfare programs are very necessary. But they should be for those who have come to the bottom of the economic ladder. The Kerr-Mills program in my own State requires an applicant to pass a rather rigid means test, even though this test is more liberal than under our old-age assistance program. Thus, in the words

of our Commissioner of Welfare, "even Kerr-Mills is still a program only for the very poor."

In the United States we have not been satisfied with only welfare programs. Early in this century we established workmen's compensation—our first venture into social insurance. Then came unemployment insurance, followed by social security. This is the American way. We ask Government to provide social insurance where such insurance will do the job better than by leaving each individual to his own resources. We do not tell the injured workman, or the man without a job, or the retired worker, to first exhaust his assets and then go down to the welfare office. We have provided social insurance benefits as the second line of defense, so that a person need not exhaust—or nearly exhaust—his personal assets.

This is why I favor the King-Anderson bill. It provides a second line of defense against the catastrophic effects of medical expenses. It is earned as a matter of right, and can be taken into account by people as they plan for their retired years, just as people now plan their retirement around social security.

H.R. 6675 is an even better bill than the original King-Anderson proposal. Besides the basic hospital and related care for the elderly, it provides for a voluntary supplementary plan covering physicians' and surgical fees and related services. In addition, it makes a number of liberalizing changes in the Kerr-Mills law, thus improving our basic welfare program.

This bill is a sensible approach to a very serious problem. It meets the needs of all Americans in the ways best suited to the individual. It is also a fiscally sound bill and will help immeasurably the financial situation of the elderly. For this reason I urge its adoption.

Mr. ADDABBO. Mr. Chairman, I rise in support of H.R. 6675. In my initial campaign for election to the House of Representatives in 1960, I pledged my support of legislation to provide a program of medical care for the aged plus needed liberalizations in the regular social security program. I believe that I have lived up to that pledge. I have been a cosponsor of the King-Anderson bill, and I have sponsored many other bills to bring needed benefits to the people.

The Committee on Ways and Means is to be commended for its dedicated work this Congress to get this measure before the House. In my opinion they have given us an excellent and comprehensive bill and one that will really meet many of the needs of our senior citizens. Through answers to my questionnaires and through direct mail to me, I know that a large majority of the citizens of my congressional district enthusiastically support this program.

In addition to the increase in monthly benefits, optional benefits to widows at age 60, liberalized eligibility requirements for disability and for persons 72 years of age or older, I was particularly pleased that benefits for children will be continued to age 22 so long as the child is attending an accredited school or college as a full-time student, legislation

which I have introduced in every Congress I have been here.

Mr. Chairman, I could speak at length on the merits of this bill, the peace of mind it will bring to our senior citizens, but it has all been said so well by our distinguished chairman of the Committee on Ways and Means that I will only say that I support H.R. 6675 wholeheartedly and I urge my colleagues to do the same.

Mr. CULVER. Mr. Chairman, the passage of the medical care insurance bill by the House of Representatives today represents a historic pledge by a nation to uphold the honor and dignity of its elderly citizens. This is particularly significant in Iowa where our 343,000 persons of retirement age represent the largest percentage of elderly found in any State.

The bill provides a wide range of insurance programs to assist in meeting the medical and hospitalization requirements of our older citizens. In this respect it combines many of the best features of the medicare, eldercare and Byrnes proposals and represents a reasonable legislative compromise in the finest sense of the word. Of equal importance, it is financed in a manner which will enable an individual to contribute substantially to the cost of his own protection; yet at the same time, the bill maintains the fiscal soundness of our social security program.

I feel that this bill successfully combines the abilities and resources of the Federal and State Governments, the medical profession, and private insurance organizations in a most desirable manner, to insure the independence of our medical profession and the personal dignity of our senior citizens.

Mr. RUMSFELD. Mr. Chairman, I have repeatedly voiced my support of the social security system, and during the 88th Congress, supported the Social Security Act Amendments of 1964 which regrettably never became law. According to the chairman of the House Ways and Means Committee, the gentleman from Arkansas [Mr. MILLS], the provisions of that bill are now encompassed by the bill we consider today, H.R. 6675, with but one minor exception.

Further, I have repeatedly voiced my deep desire to see that individuals in need of health care assistance receive that aid. Certainly, at this point in time, few in our country would suggest that those of our fellow citizens in need of medical attention should be denied that aid for lack of funds.

The real issue before the House today is not whether or not we should pass the social security benefit increases and amendments. Certainly, the vast majority of Members agree on these. The issue is not whether or not the Kerr-Mills Act should be strengthened and improved as proposed by the eldercare bill proposals. Most Members are in agreement on this. The issue is not whether the Byrnes proposal as adopted by the Committee should pass and thereby provide a voluntary insurance program covering doctor's bills and related charges for all citizens over 65 years of age. Most Members are in agreement

on this. Finally, the issue is not whether or not we should pass a measure to provide some assistance to help defray ever-mounting hospital expenses for the elderly. Most Members have demonstrated agreement on this. So, there is no real debate on roughly three-quarters of this bill.

The only real issue before the House today in the minds of the vast majority of the Members, and certainly in my mind, is which approach to this problem of hospitalization costs for elder citizens is better—that which is contained in title I of the committee bill, commonly called "medicare," or that which has been proposed in the Byrnes bill and which will be offered in the motion to recommit with instructions.

This bill is being considered under a closed rule, with no opportunity for amendment. The motion to recommit with instructions is the minority party's only opportunity to gain a record vote on any alternative proposal other than the whole omnibus bill which is voted on at final passage.

In brief, the Byrnes' motion to recommit encompasses the following provisions which are also in the committee bill:

First. The Social Security Act amendments and benefit increases as provided by the bill which passed the House during the 88th Congress, and which I supported, to strengthen, improve, and expand this program;

Second. Certain Curtis-Herlong "eldercare" proposals to amend, expand, and strengthen the existing Kerr-Mills program which I support;

Third. Some concepts of the Bow bill providing tax deductions for the cost of certain health care insurance, which I support; and

Fourth. The Byrnes proposal for a voluntary enrollment program covering supplemental medical services—doctor's and related charges—financed partly by a monthly premium and partly by general revenues which I also support.

Thus, each of these sections of the committee bill, which I support and which, I believe, a majority of the members of both parties support, are contained in the Byrnes motion to recommit with instructions.

The only major difference in the Byrnes bill versus the committee bill is title I, relating to the method of financing hospital care for the aged.

The committee bill provides for a compulsory program of hospital and related benefits, financed under the social security system by the regressive payroll tax.

The Byrnes proposal, to be offered by Representative JOHN BYRNES, the ranking minority member on the House Ways and Means Committee, is for a voluntary comprehensive program of medical insurance financed partly by premium contributions and partly by general revenues and which would in fact provide broader benefits than the related section in the committee bill.

Following is a summary description of the relative advantages of the Byrnes proposal for health insurance for the

aged prepared by the minority staff of the House Ways and Means Committee:

1. Voluntary: The basic hospitalization program in the committee bill is extended automatically and compulsorily to all eligible persons over age 65. The Byrnes program would be wholly voluntary. When coupled with the payment of a premium contribution, this reduces the duplication of coverage for those already covered under private programs. It preserves the insurance concept.

2. Contributory: In the committee bill, the hospital program is extended to all persons presently over age 65 (except certain Federal employees) at no cost. The Byrnes program requires the participants, including those presently over age 65, to make a contribution toward the cost of their insurance. This reduces the cost which under the committee bill must be borne by taxpayers under age 65. It also acts as a deterrent to excessive utilization of benefits on the part of those enrolled.

3. Not payroll financed: The hospitalization program in the committee bill is, in fact, a part of the social security tax system. An additional liability of upwards of \$100 billion is imposed on the social security tax structure by the adoption of that program. The Byrnes program is financed out of the general revenues, wholly apart from the social security system. This reliance on general revenues utilizes the general tax system, based on ability to pay. It avoids the regressive payroll tax and does not jeopardize future increases in cash benefits.

4. Flexibility: In financing the hospitalization program through the payroll tax, as a part of the social security system, the committee bill gives rise to the concept of "entitlement." It creates the erroneous impression that the wage earner is "prepaying" for a specific hospital benefit. This precludes revision of benefits in the future, except to increase the scope of the program. The Byrnes program preserves the ability to revise the programs as conditions dictate. When the insured is required to pay a premium for the benefits, both premiums and benefits can be modified as the need arises.

5. More comprehensive: Benefits of the combined hospitalization program and medical services program in the committee bill fall short of the benefits provided for in the Byrnes program. The committee bill does not meet the problem of the catastrophic illness. The Byrnes program covers the catastrophic illness up to a lifetime maximum of \$40,000 in benefits. The Byrnes bill also covers prescribed drugs while the committee bill excludes this item.

6. Lower cost: The Byrnes program provides these more extensive benefits at a lesser cost. By eliminating duplication of coverage and combining all medical benefits in a single comprehensive insurance program, it will provide more protection for less dollars.

7. Needs test recognized: The committee bill offers hospital and medical service benefits to the aged without regard to need. The Byrnes proposal provides for premium contributions related to cash benefits under social security, coupled with a tax recoupment of the subsidy attributable to individuals with incomes over \$5,000. This eliminates "need" as a basis for qualification without extending benefits to those who are, in fact, able to pay the full cost of their insurance.

8. Recognition of eldercare: The Byrnes proposal also incorporates the underlying principles proposed in the eldercare bills. It makes specific the right of the States to enter into private contracts of health insurance for those eligible under the State-administered old-age assistance and medical assistance for the aged programs.

Mr. Chairman, it is my intention to support the Byrnes alternative proposal

as encompassed in the motion to recommit with instructions. In addition to the above comments, it should be emphasized that—

First, The alternative proposal offers broader benefits for those in need. For example, the committee bill does not provide for one of the worst disasters that can strike a family today, namely, catastrophic illness, whereas the alternative proposal does.

Second, I believe that the dignity of the individual citizen requires that those who can afford to pay should pay for these expenses. However, under this compulsory system, there is no choice. Even those fortunate citizens now adequately covered by personal wealth or business, union, or private health programs will be covered.

Third, The committee bill's regressive payroll tax will hit hardest at those least able to pay whereas the general fund financing of the alternative proposal would not.

Further, if the motion to recommit fails, it is my intention to oppose the bill on final passage. Admittedly, the committee bill is neither all bad nor all good. In fact, it is considerably better now than when the administration introduced it, in that, as mentioned above, a variety of improvements have been added to it in committee such as those sponsored Mr. BYRNES, Mr. CURTIS, Mr. HERLONG, and Mr. BOW.

I would suspect that, because of the many fine, necessary provisions in this bill, many Members after supporting the alternative proposal, and if it is defeated, will vote for the bill. Just as the now popular song from "Mary Poppins" says, "a spoonful of sugar helps the medicine go down." Indeed, there is a good deal of "sugar" in the bill.

The problem in this age is one of communications. To support the alternative and then vote yes could be interpreted as being for the undesirable aspects of the bill even though the real intent was simply that the individual was for three-fourths of the bill and against one-fourth.

Conversely, to support the alternative and then oppose the committee bill on final passage could be interpreted as being against all aspects of the bill. To avoid any such misinterpretation, I am stating categorically that this is not the case.

Mr. Chairman, I am strongly in favor of most of this bill. I am equally strongly opposed to the parts of title I which provide for a compulsory program of hospitalization benefits under the regressive payroll tax of the social security system. This method of financing will prove, I believe, to be a bad mistake for the following reasons, as has been stated in the minority views and by the ranking minority member of the committee, Mr. BYRNES of Wisconsin:

1. This approach threatens social security. For the first time, a service benefit rather than a cash benefit would be tied to payroll tax under social security. The future costs of service benefits are impossible to estimate; we do know they are constantly rising in the medical field. There is a limit to the money which can be extracted from workers through a payroll tax. If mounting hospital costs raise the tax to that limit, adequate cash

benefits under social security could well be jeopardized in the future.

2. This approach is unfair to workers. The cost of the hospitalization program will be paid for by those now working. Benefits for those now over 65, who will not pay for any of the cost, will eventually total \$35 billion. A worker earning \$3,600 annually, with a wife and children to support, will pay \$250 in income and social security taxes in 1966, including \$18 hospitalization tax. A retired couple with \$3,600 income will receive the protection paid for by the young worker, yet, with lower living costs, will pay no income tax, no social security tax, no hospitalization tax.

3. A regressive tax hits those least able to pay the hardest and the payroll tax is one of the most regressive taxes known. It applies to the first dollar of earnings. There are no exemptions for dependents, no deductions for unusual expenses, no exclusions and no tax credits. There is no consideration of ability to pay. The president of a corporation pays the same amount as his worker. A man with good health and no family pays the same as a man with a large family and heavy doctor bills.

Mr. Chairman, some of the elder citizens of this Nation need assistance with the costs of health care. It is my hope that the Byrnes proposal will pass, thereby providing those individuals a more comprehensive series of benefits, on a voluntary rather than compulsory basis, at less total taxpayer cost, and financed not by the regressive payroll tax but by general revenues.

Mr. SKUBITZ. Mr. Chairman, the technique which the majority intends to follow in promoting its Great Society program is now apparent. It now appears that henceforth, the majority will draft legislation, and when the wheels have been properly greased, measures will be presented to us on a "take it or leave it" basis.

On three different occasions, I have heard President Johnson, in addressing this body, quote from verse 18 of chapter I of the Book of Isaiah, "Come now and let us reason together." I presume that I have been somewhat naive in assuming that what the President intended was that this the greatest deliberative body on earth would, after free and frank discussion, attempt to resolve its differences.

But what are the facts? This bill has come before us under a closed rule. It permits 10 hours of discussion but denies to any Member the right to amendment. I ask, what good can come from 10 hours of discussion if the right to remove objectionable provisions, clarify ambiguities, or add amendments which the majority feel might improve the bill, is denied?

Yesterday, while chatting with one of my good friends on the other side of the aisle, I suggested that perhaps we should all heed President Johnson's favorite Biblical quotation, "Come now and let us reason together." He laughed and replied, "You're right, we should reason together on our terms." He suggested that I read verse 18 which I did. Now I understand the majority position thoroughly, for I found these words:

If ye be willing and obedient, ye shall eat the good of the land. But if ye refuse and rebel, ye shall be devoured with the sword.

The bill that is before us contains 296 pages and the report that accompanies

it has 264 pages. It is one of the most comprehensive bills that has ever been presented to this body since I came to Congress. Yet open hearings were not held upon it. Interested parties were not privileged to come before the committee and express their views.

Mr. Chairman, what is wrong with open hearings on a measure of this nature which affects the lives of every person—young or old? What is wrong with letting the people know the ramifications of this bill so that they may notify their representatives of their views? Why the big rush? Congress is not adjourning. The major provisions of this bill do not become effective until July 1966 and we are talking about a bill that is going to cost over \$6 billion.

Mr. Chairman, I know of the mental anguish that our aged endure when they find themselves living on a fixed income while the cost of living continues to go up and up. I know of the fear that tortures their minds when illness strikes and they wonder whether they will be able to meet their medical bills and still be able to survive without asking for relief or becoming a drudge upon their children. Every Member of this body recognized the problem facing our aged people with respect to proper medical care. The real issue before us, therefore, is, how do we take care of those over 65? What is the best method of financing? How do we protect ourselves from going down the road toward socialized medicine?

Mr. Chairman, as the chairman of the Ways and Means Committee has stated, this bill can be broken down into four parts. First, the part dealing with medical care for our aged; second, programs for child health, crippled children and the mentally retarded; third, improvement and revisions in benefit coverage for the aged; fourth, expenses of the public assistance programs.

Last year this body passed a bill which included most of the provisions of this bill with the exception of medical care for the aged. H.R. 11865 provided for an increase in social security payments; continuing benefits for children up to 22 years of age; liberalized benefits for widows at age 60 and assistance to those over 72 years of age not previously covered. I supported this bill. It would have been law now if the Senate had not attached its version of a medicare bill to it.

The bill before us and the alternative proposal by Mr. BYRNES are quite similar in every respect. The major differences in the two proposals are their treatment of hospital care and medical services. The administration proposals provide for 60 days hospitalization and 20 days extended care in an approved facility during any one "spell of sickness." The overall maximum can be extended to 100 days if fewer days are spent in the hospital. Following each "spell of sickness" there must be a 60-day lapse following a "spell of sickness" before one again becomes eligible for hospitalization. The administration bill provides that the costs shall be borne by a payroll tax. Eligibility begins at age 65 but

the tax becomes applicable to those who pay social security. The second part of the administration medical package provides for physicians' care and additional home health visits.

The alternative proposal, by Mr. BYRNES, is by far broader and more comprehensive than that proposed by the administration. The benefits are patterned after the high option plan which we have provided for ourselves and all Federal employees. It provides for long, catastrophic illnesses. Not so with the administration bill. And how is it financed? In the first place, it is a voluntary plan. Those who care to receive it make the decision at age 65. There is no means test. Those who want it pay an average of \$6.50 per month and the remainder of the cost is paid by the Federal Government out of the general fund. Thus, the social security fund is not endangered.

Yesterday, the distinguished Congressman from Wisconsin [Mr. BYRNES] called to our attention that last year when the committee discussed the 7-percent increase, for social security, to meet the increased cost of living the administration advised that it had to be held to a 5-percent increase so that medicare could be added to social security. Let us keep in mind that as living costs go up we are going to be asked to increase cash benefits under social security. I agree wholeheartedly with Mr. BYRNES that if we tie medicare to social security then we will not have sufficient funds with which to make increases in cash benefits.

It is unfortunate that the administration has encompassed the provisions of H.R. 11865 which we passed last year into H.R. 6675 and thus place many of us in a position where we must, in good conscience, vote against the bill unless, of course, the Byrnes alternative is adopted. For many of us feel that social security must be maintained on a sound basis at any cost. That medical care must not be socialized. That our young people between the age of 21 and 65 are also entitled to some considerations.

Mr. KEITH. Mr. Chairman, in listening to the debate by members of the Democratic Party, one might conclude that we on this side of the aisle are opposed to medical care for the aged. As a matter of fact, some of my colleagues have tried to imply that we Republicans have been opposed to social security since its inception, and particularly opposed to any innovations.

I am one of many who resent these charges—and the implication that we, as a party, are opposed to the inclusion of medical care in the social security system.

I would like to remind my colleagues on both sides of the aisle that the Republicans have played a positive and, in fact, a leading role in the improvement and the expansion of the whole social security system. It was a Republican Congress and a Republican President who are to be credited with the incorporation of disability benefits into the social security system. And may I also point out that the agency which now administers this program and the other

programs of a social nature that are so necessary in this industrial society in which we live, namely the Department of Health, Education, and Welfare, is the product of a Congress and an executive branch in which the Republican Party was in the position of leadership. And certainly, many Republicans in prominent places such as the Congress, the Cabinet, industry, and the State legislatures have consistently sponsored a sound and reasonable expansion of social security. They have been vitally interested in the proposition that the system be expanded to take care of the unpredictable and extraordinarily costly expenses of medical care that threaten those who are retired under the benefits of the Social Security Act.

I know, of course, that individuals on both sides of the aisle have historically opposed development of this social security system—and that they have had the right and the responsibility to express their sentiments on this subject. But certainly the public recognizes that both parties have, on balance, shared this concern and supported the development of this program.

In recent years, while medical science has helped add considerably to our lifespan, the costs of hospital care have increased from \$4 a day to, in some parts of the country, \$40 a day. And sociologists, both within and without the Government, have been seeking some way to help shoulder this prospective burden of hospital expenses—a burden which could not have been foreseen during the working years of those who should now be able to enjoy in retirement the fruits of their labors.

More than 3 years ago, in a newsletter to my constituents, I discussed this entire question. And, Mr. Chairman, for the record, I would like to include in my remarks excerpts from that newsletter of March 1962, I said:

My studied conviction [is] that social security is the logical vehicle to finance hospital and nursing home care for the elderly.

Both political parties are agreed that a substantial number of those over 65 have inadequate income, insurance, or savings to pay for the extensive hospitalization or nursing home care which old age often requires. Recognizing Federal responsibility to meet this need, Congress acted under the general "welfare" clause of the Constitution in 1960. Under Kerr-Mills, Federal funds were provided to match State and local contributions for paying the medical bills of those aged persons who cannot afford the care they need.

This approach has serious weaknesses. Social security financing, however, makes it possible to save during working years for the expense of hospital and nursing home care during retirement years. It enables the costs of the program to be borne by those who will receive the benefits. It is a "user's tax." It does not affect the relationship of doctor and patient, nor provide for the payment of doctor bills, so it avoids the dangers of socialized medicine—most importantly, it would preserve individual

responsibility and personal dignity, because recipients would have made contributions to their own future.

I went on to say, in conclusion, in this newsletter that:

The issue then is a very simple one; what is the proper way to provide for the payment of our hospital bills when we are no longer working and earning a salary?

In the years that have intervened since I first became involved in this subject, I have publicly suggested that the Government, the insurance industry and the medical profession should get together and come up with an adequate proposal. They have failed to do so.

In my most recent newsletter I had this to say about medical care for the aged:

The administration wants a medicare program and, controlling Congress as it does by a 2-to-1 majority, it will have its way. It seems settled now that financing will be on a pay-as-you-go basis, with contributions coming from both the employer and employee.

It's quite possible the final plan will not be as elaborate as the administration proposal—and will provide only for hospital care. This protection will be paid for during the employee's working years.

To supplement this basic program, if the plan is enacted as I have projected, the individual could buy (hopefully for a very modest premium) coverage from an insurance company or through Blue Shield. (Such coverage would pay doctors' and surgeons' fees, as well as extra hospital expenses.) Those unable to pay these premiums, or unable to pay medical costs out of pocket, could still obtain help from medical assistance for the aged under currently existing State-Federal programs.

But the Ways and Means Committee did not stay with the original and basic proposal. Largely under the stimulus of the American Medical Association they added two layers of frosting to a cake that was, in my opinion, adequate to do the job in the first instance. And, in so doing, they have made the plan much more extensive than is necessary.

My objections to the committee's bill concern the second and third layers of the medical care "cake." Like the Byrnes plan, they involve a very significant departure from the principle of social insurance. This optional plan should be opposed because the Government is, in effect, subsidizing the insurance industry. This could lead to Government intrusion on a large scale—ending possible in a Federal insurance plan whereby a person could choose to buy insurance from either the Government or a private company. This has happened in other parts of the world.

In addition, this portion of the bill presents the possible threat of eventual socialization of the medical profession—although this program is the outgrowth of the proposals advanced by the AMA under their eldercare bill.

In my view, it would have been much better had we adopted the original medicare proposal and built on that with private insurance plans.

However, in conclusion, Mr. Chairman, the basic proposal of the original bill—that hospital costs be financed through the social security system—is still a major part of the legislation being debated.

It gives the American people the opportunity to finance hospital care for the aged in accordance with sound fiscal principles. On balance, therefore, taking the bad with the good, I shall support the Ways and Means Committee's proposal.

I must say, however, Mr. Chairman, that it is my hope that the Senate will review this legislation and the debate which has taken place in the House. With the more open rules of that body, it is hoped that a bill will be perfected that will solve the basic problem of providing for the hospital costs of our aged citizens. At the same time, this legislation should assure that necessary supplemental protection be achieved in a way that will allow more flexibility and freedom of choice than that contained in the proposal which will be passed by the House today.

Mrs. MINK. Mr. Chairman, it is with sincere enthusiasm that I rise to support this most progressive piece of legislation, which goes far toward meeting the needs of our elderly citizens.

For many years now, the country has debated its national responsibility for providing our senior citizens that kind of hospital care which is both dignified and adequate. At first, its opponents challenged the need; later they admitted the need but argued that a means test was necessary and, further, that the program should be voluntary.

We have tried to solve this serious problem by permitting the means test to be set by the States, but this provided help for only a small percentage of the elderly. As this crisis worsened, private voluntary plans groped and yet failed to meet the growing needs on a realistic basis.

This bill, which I am confident will become law, meets this challenge of providing the elderly adequate medical care in sound and fiscally responsible manner.

First, virtually all of the 19 million persons now over age 65 can be assured of reasonable hospital care under this basic plan of protection. It provides benefits including 60 days of hospital inpatient services for each spell of illness, of which \$40 is payable by the beneficiary; from 20 to 100 days of posthospital extended care in a facility having an agreement with a hospital to provide such services; outpatient diagnostic services as required, with a \$20 deductible provision which is credited against the hospitalization deduction if the patient is hospitalized within 20 days after undergoing a diagnostic study; and up to 100 posthospital home health service visits after discharge from a hospital or extended-care facility.

This program would be financed the first year by a separate insurance payroll tax of 0.35 percent, with the maximum earnings base set at \$5,600 through 1970. The same rate would be paid by employers, employees, and the self-employed.

Two million persons not covered now by the social security or railroad retirement systems will be covered by this program.

As the program matures, virtually 100 percent of the elderly will come under

its provisions, and the trust fund will be self-supporting.

Second, a voluntary supplementary health insurance plan will enable the aged to cover the greater part of their doctors' and other medical and health bills by payment of a small monthly premium of \$3. It is estimated that 80 to 95 percent of those eligible, or 15.2 to 18 million individuals, will avail themselves of this provision.

Benefits, after a \$50 annual deductible provision, will include 80 percent of a patient's bill for the following services: Physicians' and surgeons' fees in hospital, home, or office; up to 60 days' mental hospital care per mental illness, up to a lifetime maximum of 180 days; up to 100 days of home health services, whether or not the patient is hospitalized; such medical services as X-rays and lab tests, dressings, splints, and certain ambulance and medical equipment costs, and up to \$250 worth of mental, psychoneurotic, and personality disorder treatment outside hospitals.

To finance this plan, initial enrollees would pay a premium of \$3 a month, to be matched by Government contributions. Premium costs would be fully met by an increase in social security benefits.

To encourage the purchase of hospital insurance by all taxpayers, a new tax deduction will be permitted of half the cost of hospital insurance premiums, whether or not these are in excess of the 3 percent floor on medical expenses, if the taxpayer itemizes deductions.

Additionally the bill provides that the States will receive additional Federal aid, not only for the aged but for the blind, the disabled and dependent children programs.

It is estimated that the new program will increase the Federal Government's contributions by about \$200 million over existing programs in the first full year of operation. This increase could rise to an estimated \$238 million if all States take full advantage of the program.

The bill also includes several extensions and improvements of basic social security provisions. It is estimated that 20 million persons will benefit from the 7 percent—\$4 minimum—increase in cash benefits. The maximum payable benefit for a family would rise from the present \$254 to \$286.80. It is estimated the 7-percent increase will result in \$1.2 billion in additional benefits in 1965 and \$1.4 billion in 1966.

Another provision increases the duration of dependent children's benefits up to 22 years of age if they are enrolled in full-time educational programs. Currently these dependent children's benefits are cut off at age 18. For most children, this will mean the continuation of these benefits for the time it takes to complete a 4-year college course.

Still another provision of the bill will allow widows to qualify for benefits at age 60. At present, widows are eligible for survivors' benefits at age 62. Under this provision, they can elect to take reduced benefits at age 60.

The bill also has several other liberalizing provisions, among them one allowing payment of a wife's or widow's benefits for certain divorced women who

had been married at least 20 years before the divorce.

The bill also includes a noteworthy child health program, including a new provision establishing a five-year program of comprehensive health care for children of preschool and school age, with emphasis on those from low-income families.

A total of \$185 million would be authorized for this new and forward looking diagnosis and treatment program. In addition, the bill would: Boost authorizations for existing maternal and child services by \$5 million in each of the next 3 years and \$10 million annually thereafter; boost authorizations for existing crippled children's services by the same amounts; authorize appropriations of \$15 million in the first 2 years and \$17.5 million annually thereafter to pay for training of professional persons to work with crippled children including the mentally retarded, and authorize payment for hospital expenses of beneficiaries under the maternal, child health and crippled children's programs. Also authorized is a \$5.5 million, 2-year program of mental retardation planning.

Surely, there can be no greater goal than that of a healthy mind in a healthy body. I am particularly happy to point out that the role of the physician as our chief and guiding light is recognized and upheld in the provisions of the bill. Not only is the Federal Government specifically prohibited from exercising control over the practice of medicine and operation of medical facilities, but the physician is acknowledged as the determinant of treatment needs.

Mr. Chairman, this bill can go far to supplement the efforts already started to provide all of our Nation, young and old alike, with the fullest measure of the benefits of the advances of medical science.

Mr. Chairman, this bill is a landmark of enlightened legislation. It provides, on a sound financial basis, a comprehensive and farseeing approach to solving one of the most vexing problems of our society, to wit adequate medical care. I strongly urge my colleagues to support it.

Mr. TUNNEY. Mr. Chairman, today, I am giving my full support to a bill which will give our 18 million senior citizens protection against the high costs of medical care.

No issue facing our country at this time shows more clearly the work that must be done before we can truly fulfill the dream of a great society. The fact that we are presently voting on this matter shows that we are progressing toward a society which adequately meets the medical needs of its citizens.

Not since the days of Franklin D. Roosevelt have so many people fought so hard and displayed such great support for a single piece of legislation. At that earlier time a social security insurance program was enacted to enable a person during his productive years to set aside a small amount of his wages so that he would have a guaranteed income upon disability or retirement. The Social Security Act is one of the great landmarks of American history.

Today we are entering the second stage in this long fight by expanding social security to insure care for the medical needs of our senior citizens.

How can we stand idly by while serious illness wipes out retirement savings of many of the aged.

The war on poverty will reach a new level of intensity with the passage of this medical care bill.

I am sure that we all want a society which protects its citizens against poverty and gives them the best opportunities for advancement.

The medical care bill we are considering today will be amongst this generation's greatest contributions to the well-being of Americans and I am proud and humble to stand beside those who will cast their votes in its favor.

Mr. CLEVELAND. Mr. Chairman, the Republican medical-care proposal to be offered as the Byrnes amendment, is far superior and much fairer than the administration's medical care plan, which is included as part of H.R. 6675, the Social Security Amendments Act of 1965.

I shall vote for the Republican amendment and I urge the House to accept it in place of the administration's bill. If the Republican amendment is not adopted then I shall vote for H.R. 6675 but with some reluctance.

While I am glad that Congress is about to enact an improved program of medical care for the aged, I am sorry that it has chosen what I consider a less satisfactory plan than some of these which have been proposed. It is regrettable that the issue of medical care for the aged is not presented to the House as a separate bill rather than as part of a massive program of social security reforms which includes many areas not related to medical care problems. This method of mixing a variety of major issues in one bill may be clever politics but it is a bad way to legislate. It is indeed regrettable that a bill 296 pages in length has not been scrutinized at public hearings.

MANY IMPROVEMENTS IN BILL

The bill contains many improvements which I have urged since I came to Congress. I am in accord with amendments in the bill which would increase benefits by 7 percent across the board with a \$4 minimum increase for a worker although I do not consider these increases enough for those in greatest need. I am also in accord with amendments to continue benefits to age 22 for certain children while they are in school, provide tax-exemption for certain religious groups, such as the Amish, liberalize and clarify the definition for disability insurance benefits, and increase the amount an individual is permitted to earn without suffering full deductions from benefits. I voted for all of these improvements that were offered in last year's bill, and have urged adoption of the others. The monthly increase in benefits to the very needy, however, are far too low as I have indicated.

The minimum benefit that a person can now receive under social security is \$40 a month. This bill would raise that to the "munificent" sum of \$44. This

does not begin to touch the amount needed to make up for the increasing cost of living caused by the lowered buying power of the dollar—in other words inflation.

GOP PLAN BROADER AND SOUNDER

If the Republican medical care program were adopted instead of the plan that is in this bill, additional funds would be available to bring these monthly benefits to a realistic level. That is because the Republican program would cost less at the start and would not become the great burden on the social security system which the administration program will be.

It is unsound to lock the medical care program into the social security program. This means the imposition of a heavy payroll tax that is scheduled to be increased over the years and which may well have to be raised far beyond present expectations.

A payroll tax is the harshest kind of tax. It is paid by rich and poor in equal amounts. It falls lightly on the rich but presses heavily upon those of modest means, and is bad for small business. The president of a corporation pays the same as the employee and both will usually receive the same benefits.

ONLY LIMITED FUNDS AVAILABLE

There is only so much money available for medical care. Every drain on the total pool for unnecessary purposes lowers the amount available for vital purposes—that is, helping those that are in real need. Yet, under the administration's bill, large sums will be allocated to those who can pay their own bills. Other basic Federal programs recognize this and are geared to place their benefits where they are most needed. Federal housing, veterans pensions, student loans, old-age assistance, aid to dependent children, and others help those in need but cannot be used to enrich those who are not.

Furthermore, the new schedule of payroll taxes imposed by the bill threatens to wipe out the benefits of the income tax reductions for many.

OTHER GOOD AMENDMENTS IN BILL

There are other amendments in this bill which I have supported in the past; providing for medical aid to dependent children, the blind, and the disabled; services for maternal and child health, crippled children, and the mentally retarded; and a 5-year program of special grants for health services for children. I fully support these amendments.

I also support the system of voluntary insurance that will supplement the basic medical care provisions. We Republicans have consistently pointed out the inadequacies of that basic program and I wish only that Republican principles had been adopted for the entire plan.

The Republican program would be financed wholly apart from the social security system and would never threaten the ability of the system to meet future increases in cash payments. Under the Republican program, a participating individual would pay only when he reached the age of 65, not for up to 44 years in advance. It would be voluntary and

would reduce or eliminate the duplication of coverage for those who already have private programs.

The administration bill does not meet the problem of catastrophic illness. The Republican bill covers catastrophic illness up to a lifetime maximum of \$40,000. Drugs and physicians' costs also are included in our bill but the administration bill omits these.

The Republican bill is flexible and could be opened up or changed with relative ease in the future. The administration's bill is rigid and will not be easy to alter.

It is well to enact a medical care program, Mr. Speaker, but let us do it wisely. We are building something permanent for all the foreseeable future. Let us do it right at the outset.

Mr. PUCINSKI. Mr. Chairman, I rise in support of this historic legislation which will give our Nation's senior citizens a new lease on hope and confidence during their major illnesses in old age.

This undoubtedly is the most significant piece of legislation to come before the Congress of the United States in this decade.

The provisions of this historic bill are sweeping in scope, but they have been carefully designed to provide the highest degree of protection for the complete freedom of the American medical profession, while at the same time giving our senior citizens full access to their hospital and surgical needs in old age.

I have never been more proud to cast my vote for any legislation than I am today in support of this medicare bill.

This bill also provides for our senior citizens a 7-percent across-the-board increase in their monthly benefits, with a \$4 a month minimum for those who have retired at age 65 or older.

It provides continuing benefits to age 22 for children attending school. It also provides actuarially reduced benefits for widows at age 60.

This bill also liberalizes the definition and waiting period of disability insurance benefits, thus providing a new source of assistance to those heretofore denied disability benefits under social security.

It also provides for the payment of benefits on a transitional basis to persons currently 72 years of age or older who are now ineligible.

This bill also increases the amount an individual is permitted to earn without losing social security benefits.

This bill also, for the first time, brings under its coverage self-employed physicians, waiters and waitresses, and other people whose main source of income comes from cash tips.

The medicare amendments and other amendments being proposed here today constitute the most sweeping overhauling of the Social Security Act since its adoption some 30 years ago.

Every one of these amendments has been carefully considered in the light of the good it will do for the people of America.

Mr. Chairman, I think it is significant to see how many people will benefit from each of the categories provided in this bill.

More than 17 million senior citizens who are now drawing social security benefits, and 2 million additional old people who are not under social security will qualify for extended hospital coverage beginning July 1, 1966.

These senior citizens will be able to select their own doctor and the hospital of their choice for their hospital care under this bill.

A similar number of Americans will be able to purchase additional coverage to include all surgical care through the doctor of their own personal choice for the modest sum of \$3 a month.

Also, Mr. Chairman, 20 million Americans now receiving social security benefits will receive the 7-percent increase in monthly benefits. In the case of a husband and wife who are on social security, the 7-percent increase will apply to each individual.

More than 295,000 children will continue to draw social security benefits up to the age of 22 if they are in school.

More than 185,000 widows will come under social security coverage through the reduced age for widows in this bill.

An additional 355,000 persons will be able to benefit from social security payments under the reduction in eligibility requirements for certain persons age 72 or over under the bill before us today.

Finally, Mr. Chairman, an additional 155,000 workers and dependents will be able to qualify for social security benefits under the liberalized requirements for disability.

Throughout my district, Mr. Chairman, tens of thousands of my constituents will find increased benefits under the bill we are about to approve today.

Mr. Chairman, I think it is important to note the additional cost of these benefits to all wage earners effective January 1, 1966.

Under the provisions of this bill the average American worker will contribute an additional \$20 in 1966 for the extended hospital benefits to senior citizens. In 1967 the figure will go up to \$28 a year. In 1971 it will go up to \$33 a year. By 1975 it will go up to \$36 a year.

This additional money will be placed into a special health benefits fund and will not be commingled with the rest of the social security funds from which senior citizens draw their monthly retirement benefits.

I am confident that when those who oppose medicare become fully familiarized with the provisions of this legislation and especially the unequivocal guarantees against any socialization of the American medical profession, they will be satisfied that this is very worthy legislation.

Mr. DUNCAN of Oregon. Mr. Chairman, one of the great rewards of legislative service is to watch the growth of a great legislative concept. From its birth as an idea of the mind, perhaps, of a single citizen, through the long years of tempering, in the forge of public opinion and legislative debate, to its maturity, as the law of the land.

The course is frequently a stormy and tortuous one, it is seldom a straight one, it is often a long one. And on this voyage

the child gets stronger and stronger, sometimes appearing to go under but always reappearing.

With respect to these major concepts one knows, or one senses, that time is on their side. They will, ultimately, prevail. And there inevitably comes a time when they must prevail, because they have grown in the great democratic marketplace of ideas into adulthood.

Along this tempestuous course many contributions are made to the vitality of this idea. Some contributions come from friends, some from foes; each adds to its strength.

So with medical care to the aged. The time is ripe. The idea whose time has come and, than which there is no stronger force, is upon us. It has thrived on praise and, even more, on criticism for from its severest critics have come its most vigorous attributes.

I have been criticized for saying that I hoped ultimately out of this crucible would come a bill which would enjoy the support of all. There were those who wrote and said that anything the doctors were for they were against, for the doctors had been the most vigorous of medicare's enemies. With these people I disagreed, for upon the medical profession depends so much the success or failure of this great innovation in American life—for these people, are the practitioners of the healing arts who have made in our time progress far exceeding our fondest dreams. Without their cooperation, tacitly or otherwise, this bill cannot succeed. I am confident it will have their support for the will of the majority will today speak. And the Nation will enjoy, as always, their wholehearted cooperation.

And while this bill does not today yet enjoy the vocal support of the medical profession, it will tomorrow. Today this great legislative concept is ripening into maturity and no group has made a greater contribution toward its ultimate shape than has the medical profession albeit unwillingly and perhaps unwittingly.

The doctors' greatest fear has been not that King-Anderson included them within its bounds for it did not. They feared rather their eventual inclusion in proposals still to come which they feared would destroy their freedom and their historic patient-doctor relationship. I have consistently advocated that provisions for the handling of doctors' bills be frozen at the outset into the private sector of our economy—handled through private insurers—so as to obviate that fear and so as to broaden the coverage. Today we have accomplished this. Tomorrow the medical profession will laud our wisdom.

We have further insisted upon a deductible provision, to guarantee, as near we can, against abuses, though we have still another guarantee; namely, the integrity of the medical profession who will, I know, require hospitalization for none who do not need it, but who will be able to prescribe solely for medical reasons, rather than having their judgment contaminated by economical considerations unrelated to the requirements of the infirmity.

In effect today we free the medical profession in the treatment of the aged from shackles forged from dollar signs.

The integrity of the old-age and survivors insurance fund and the disability fund is preserved. Traditional social security benefits and an improved Kerr-Mills is made more workable. In short, many of the valid criticisms levelled at the King-Anderson proposal have been silenced.

Costs, we were told, are high. There is no change in the costs. The need exists as everyone now admits. We will either fail to meet that need—which no one advocates—or we will pay it one way or the other—by private charity, by service rendered free of charge by the doctors themselves, or by an insurance program paid for by those who use it, making contributions during the productive years of their lives, that they may have security and care during their nonproductive years. There is no cheap way—neither the way we are now inadequately meeting the need, nor the alternate Byrnes proposal, nor to what we will this day do. We choose today only between methods and are choosing one which will render service with dignity, and which will permit the medical profession, to which we owe so much, to continue to practice with freedom and with dignity. I would, as would all of us, prefer that this problem would have been handled by the private insurers. But they have not and, I am convinced, cannot.

Today our elder citizens will thank us, tomorrow the medical profession and the entire country will thank us.

Mr. RANDALL. Mr. Chairman, in just a few moments we are going to be asked to vote on the substitute proposal of the gentleman from Wisconsin [Mr. BYRNES]. As we deliberate whether to accept the substitute, it is important to keep firmly in mind the general provisions of the main bill as reported by the committee. Therefore, let me recapitulate briefly a few salient points about the basic structure of the committee proposal.

In addition to the health care package contained in H.R. 6675, the committee bill provides for improvement and expansion of benefits in the social security system and for certain other improvements in child care and public assistance programs. These provisions do not seem to be contested on either side of the center aisle, but they are nevertheless important.

The old-age, survivors, and disability insurance program will be improved in several important respects. First, the beneficiaries of the social security program will receive an across-the-board increase in benefits of 7 percent, with a minimum increase of \$4 per month. Second, payment eligibility requirements will be liberalized to permit assistance to some 990,000 new beneficiaries—295,000 dependent children will benefit by receiving benefits when they continue in school up to age 22; 185,000 widows will be able to participate in the program at age 60 by receiving actuarially reduced benefits; 355,000 persons 72 years and older will be able to receive transitional

social security benefits for the first time. Finally, 155,000 workers and dependents will receive eligibility as a result of much needed changes in definitions under the disability benefit program.

The medical package contained in the Social Security Amendments of 1965 is divided into three separate, but complementary, packages. They are first, a basic plan of hospitalization and nursing care insurance; second, an optional program to pay for doctors' fees and other specialized health care; and third, improvements of existing medical programs under the social security and Kerr-Mills programs. It is here that the controversy centers, for these are the provisions which would be changed under the Byrnes substitute.

The first part of the medical package is establishment of a separate social security trust fund, financed through a separate payroll tax, to provide protection against the cost of hospital and nursing care. With certain revisions to protect further the independence of specialized medical personnel, this part of the package is similar to the so-called King-Anderson proposal. Persons entitled to benefits under the plan would be eligible to have payments made for inpatient hospital care and for important additional benefits covering post-hospital extended care, posthospital home health services, and certain outpatient hospital diagnostic studies. Over the long run, virtually all citizens who have attained the age of 65 will earn entitlement for this program.

The second part of the medical package is a supplementary and voluntary program providing money for the payment of physicians' fees and other medical and health services over and above those contained in the first part. This program of voluntary insurance would cover physicians' services, additional home health visits, care in psychiatric hospitals and a variety of medical and other services not covered in the basic hospital insurance plan. The plan will pay for 80 percent of the cost of such services above an initial \$50 deductible.

This optional program will be financed through \$3 monthly contributions from individual participants, matched by \$3 per participant paid from general Federal revenues. Since the minimum increase in social security payments will be \$4, most older citizens will have additional income available to make payments. However, changes have been made in the Kerr-Mills program to permit the States to make a \$3 payment on behalf of any individuals who for financial reasons would be unable to enroll in the plan.

Mr. Chairman, inclusion of this supplementary option in the committee bill has met one of the major criteria on which I have previously conditioned my support for medical care to the aged. I have always believed that once the most basic and most expensive medical needs have been guaranteed, the Congress should permit the individual to decide for himself the extent to which he further desires to receive federally supported medical care. Now, under this bill, the citizen will not only have an option re-

specting payment of physicians' services, but he will also get an additional tax break on any private health insurance program in which he might wish to enroll.

I might also point out that provisions relating to payment of doctors' fees under this section of the bill are almost identical to provisions governing payment of doctor bills in the Republican substitute motion. Physicians are given identical treatment in both proposals. As Chairman MILLS so eloquently pointed out in yesterday's debate, there is not one solitary thing in this committee bill that carries any threat to the medical profession of this country that could not also be said of the bill offered in the form of a substitute by the gentleman from Wisconsin.

Both bills deal only indirectly with physicians. Both bills permit the physician to make his own payment arrangements with patients if so desired. And both bills leave the choice of physician up to the individual enrollee. Moreover, both bills have strong provisions giving physicians, through their professional associations, a large role in establishing standards for quality medical care.

A third part of the medical package in the committee bill is a group of revisions which improve existing provisions of the Kerr-Mills program, by which generous Federal matching grants enable the States to provide medical care on behalf of aged persons having enough income for their basic maintenance, but not enough income for medical care costs. These changes will have at least three beneficial effects.

First, they guarantee that if State medical care is given to the needy, it will at least provide for payment of deductibles under basic hospital insurance provisions of the main bill. Such deductibles amount to the first \$40 of inpatient hospital care, for each spell of illness, and \$20 for outpatient diagnostic services.

Second, all needy persons receiving medical benefits under current provisions of the Social Security Act will receive equal treatment from the States under the new law. No State plan will be permitted to discriminate in eligibility requirements or in amount, scope, or duration of medical assistance among different groups of the needy recognized by State or Federal laws. Thus the most needy in a State having a Kerr-Mills type program will receive no less comprehensive care than those who are not as needy. The blind, the permanently disabled, the dependent children, and the elderly who now receive medical aid under existing social security provisions would be made an integral and equal part of any Kerr-Mills program of aid to the needy.

Third, the Kerr-Mills changes include certain minimum program standards designed to eliminate inequities in some State programs, as revealed in recent House and Senate testimony. The most important of these standards relate to eligibility requirements for participation in State programs. Under existing law, several States have been permitted to establish so-called means tests, setting a

hard and arbitrary cutoff point for medical assistance related solely to personal income. Henceforth under the changed committee bill, any financial eligibility tests will have to take into account the financial burden caused by the illness itself, in addition to the regular income of the recipient. Thus in no instance may a State require the use of income or resources which would bring the individual below the test of eligibility under the State plan. For instance, if the test of eligibility should be \$2,000 a year, an individual with income in excess of that amount shall not be required to use his income to the extent he has remaining less than \$2,000. This simple change makes the Kerr-Mills program far more workable and equitable than it was as originally written.

What does the gentleman from Wisconsin propose to substitute for the program I have just outlined? The gentleman would preserve intact all provisions relating to social security revisions and public welfare. He and his colleagues would even accept as beneficial the Kerr-Mills changes, despite traditional Republican dissent from previous Democratic critiques of its inadequacies. But in place of the two separate programs to provide adequately and conservatively financed medical care to the aged, he would substitute a single voluntary insurance program financed by recipient payments and from general Federal revenues.

Mr. Chairman, I am opposed to this substitute proposal. I am not only opposed to the false claims that it would treat the doctor-patient relationship differently than the administration bill, but I also reject the absurd claim that somehow the Republican substitute can provide more care for less money. There are only two ways that the substitute plan could cost less, and provide more benefits. One would be to use different and less conservative assumptions about the expected cost of medical services. The other would be to pass the costs on to the elderly themselves. The first would be fraudulent, and the second would be cruel.

But Mr. Chairman, we can take the gentleman's cost estimates at face value. The big argument still remains that the Republican proposal will be paid for out of tax funds, whereas the committee bill will be based on a payroll deduction which would be an element of cost and absorbed as a part of production. Those who are really sincere about deficit financing and those who are honestly concerned about the size of our national debt should be genuinely concerned about the Byrnes proposal to increase our national debt by \$3 billion. Not only will the proposal lead to an initial debt increase, but it will also be more likely to expand rapidly than a program based on payroll taxes.

I hazarded a prediction in debate earlier today that when the present opponents find out what the real content of this measure is, they would change and become its strongest proponents.

I am going to be brave enough to make a second prediction. It is that this bill will become increasingly acceptable to the medical profession. Over the years

ahead physicians will look upon the plan with enthusiasm along with all the recipients as they see the plan in operation.

Today is a historic day in this House. The scene here is quite dramatic because within the past 10 days this House of Representatives will have passed two historic measures—the bill to provide for Federal assistance to elementary and secondary education, and this great health bill. If there was ever an instance of democracy at work in a constructive manner and in a cycle of dynamic action, it has been in the last 2 weeks in this House of Representatives.

Mr. QUIE. Mr. Chairman, I have just had to make the most difficult decision of my political career.

There are many portions of this bill to provide medical care for the aged which I support. Many of these portions I have long advocated and I must admit that it is with great regret that they are united in the same bill with such an unwise, unsound, and regressive method of taxation to finance one portion of this bill as is the payroll tax. It is unreasonable in the threat which it poses to the entire social security system, which is the basic retirement system on which millions of our elderly people depend. It is unsound in that it is unfair to those who are now working. It is regressive because it puts the heaviest burden on those who are least able to pay.

Mr. Chairman, it is my duty as a Congressman to think not of political benefits, not of just one segment of our population, but of every citizen. I believe that a bill which discriminates against one portion of the population in order to give vast compulsory benefits to another segment is unjust and unfair. I think that any bill which threatens the future well-being of any segment of the population by threatening the retirement benefits for which they have paid throughout their working lives is unjust and unfair.

If I were to stand alone in my opposition, I would have to do so, for this is a matter of principle and this bill is wrong in principle.

And I regret it, because it applies only to one portion of the bill. That is the "hospicare" portion which was originally sold to the American people under the false label of "medicare." It took the energy and devotion to fairness and duty of the Republican side of the aisle to bring this bill as far along the road to equity as it has gotten. Unfortunately, the last milestone toward reason will have been missed if this afternoon's motion to recommit does not prevail. If it does, I can wholeheartedly support this measure when it comes back in revised form.

And what, you ask, do I find wrong with the "hospicare" portion of this measure?

First, it is a threat to the entire social security system. There are over 20 million Americans drawing social security benefits right now. Are we to risk their futures for the sake of what started out, at best, as a hastily concocted political pipedream of the 1962 elections?

It would risk the entire social security system because the future costs of service benefits are impossible to accurately estimate. We do know that the costs

of hospital services are constantly rising. There is a limit to the money that can be extracted from the workers through a payroll tax. And we do know that both of the existing funds—both the disability trust fund and the old-age assistance trust fund—have been constantly shrinking. If mounting hospital costs raise the amount of benefits, the entire social security system could well be in jeopardy.

Second. It is unfair to workers because, in its regressive nature, it is begun on the first dollar earned and continues up to \$5,600 of earnings, where it stops. In other words, the worker on the assembly line or in the office or on the farms pays just as much as does the president of the corporation.

As my colleague, the gentleman from Wisconsin [Mr. BYRNES] who has sponsored such an outstanding alternative to this bill has pointed out, a worker earning \$3,600 annually, with a wife and two children to support, will pay \$250 a year in income and social security taxes in 1966 if this bill passes. A retired couple with \$3,600 income will receive the protection paid for by the young worker, yet, with lower living costs, will pay no income tax, no social security tax, and no hospitalization tax.

Mr. Chairman, I submit that when the elderly people of this Nation find out what this program is doing to their children that they will find no justification in it. But they will not be able to drop it—for it is compulsory.

As can be seen from the illustrations this regressive tax hits those least able to pay the hardest. And I note that there are no exemptions for dependents, no deductions for unusual expenses, no exclusions, and no tax credits. There is no consideration of ability to pay. A man with good health and no family pays the same as a man with a large family and heavy doctor bills.

Back home in Minnesota, they are now debating the merits of a State sales tax. The argument is often used by the Democratic administration of my State that a sales tax is "regressive." Mr. Chairman, a sales tax pales in comparison to the insidious regressiveness of this tax which the national Democratic administration now offers.

Mr. Chairman, in good conscience can I—can any of us—threaten the retirement benefits of 20 million Americans, place our children and our children's children under the grinding yoke of taxation which this bill promises and, to complete the calumny of the situation, take heaviest by comparison from the "have-nots" rather than the "haves"?

Mr. Chairman, my conscience does not allow it. If this payroll tax is not removed from this bill, I will vote "no." I would hope that a majority of my colleagues would do likewise. There is nothing sacrosanct about H.R. 1—the King-Anderson bill—which heads this bill. There is nothing sacrosanct about the idea of this being "our No. 1 item of business."

As far as I am concerned, it is still a No. 1 item of business—if we can only start over and have a reasonable bill.

In this regard, I would like to commend the gentleman from Wisconsin

[Mr. BYRNES] who has sponsored the Republican alternative of which I spoke earlier. It is a fine piece of legislation. Some portions of it have been incorporated into this bill now before us.

I should also like to commend the American Medical Association for giving us the benefit of the eldercare proposal. I note that portions of it have also been included in the final version.

If either one of these two pieces of legislation stood before us alone, I could support them. Chopped up, tacked to-

gether and imprisoned side by side with the regressive features of hospicare they are robbed of much of their potency. But I predict that if this unwise measure gains passage that these two portions of the bill are the ones which we shall remember as having truly been in the interests of the American people.

I should also like to commend the committee and all those responsible for including a liberalization of basic social security benefits in this bill, although I believe they should have been considered

separately so that all of us could have voted in favor of them. I have long advocated them. After all, there has been no increase in these benefits and no liberalization of requirements since 1958 and the cost of living and many other economic factors have changed drastically since that time.

Mr. Chairman, I believe that a comparison of the Republican substitute with the committee bill now before us will clearly show why I support this substitute which will be offered by the gentleman from Wisconsin [Mr. BYRNES].

Comparison of programs of health insurance for the aged

	Committee bill (H.R. 6675)		Republican substitute (H.R. 7057)—Comprehensive insurance program
	Hospitalization program	Medical services program	
Eligibility.....	Persons over age 65 (excluding Federal employees retired after 1959) without regard to social security status, and persons reaching age 65 after the year 1967 with required social security coverage.	All persons over age 65 without regard to social security coverage.	All persons over age 65 without regard to social security coverage.
Enrollment.....	No enrollment required.	Enrollment and payment of premium required. Premium may be paid by social security allotment.	Enrollment and payment of premium required. Premium may be paid by social security allotment.
Cost to the insured.	Benefits extended to eligible persons without cost to the insured.	Premium contribution of \$3 per month required of the insured.	Premium contribution required of insured based on cash benefits under social security. Average premium about \$6.50 per month.
Benefits.....	<ol style="list-style-type: none"> 1. Hospital charges for up to 60 days of hospitalization followed by 20 days of nursing home care subject to a \$40 deductible. Hospital period may be exchanged for nursing home care on a 1-to-2 ratio up to a total of 100 days of nursing home care. Benefit limitations apply to a "spell of illness," which continues until lapse of 60 consecutive days during which no benefits are received. 2. Home health services up to 100 visits following a period of hospitalization. 3. Hospital outpatient diagnostic services subject to a \$20 deductible for each 20 days. 	Physicians' and doctors' services, home health services, limited psychiatric hospitalization, and miscellaneous medical services in and out of medical institutions, subject to a deductible of \$60, with 20 percent of the charges to be paid by patient.	<ol style="list-style-type: none"> 1. Hospital charges for room and board up to \$1,000 without a deductible. 2. All additional hospital charges, including room and board subject to a deductible of \$25 with 20 percent to be paid by patient. 3. Any and all other recognizable medical expense, in or out of the hospital, including physicians, surgeons, private nurses, and prescribed drugs. Subject to a deductible of \$25 to \$50 overall, with the patient paying 20 percent of the charges. 4. Benefits are subject to a lifetime maximum of \$40,000, with restoration of maximum where annual benefits do not exceed \$1,000.
Financing.....	Payroll tax beginning with a rate of 0.70 percent on \$5,600 and increasing to a maximum of 1.60 percent on \$6,600, applicable to employers, employees, and self-employed alike.	Premium contributions by the insured (½) and general revenues (½).	Premium contributions by the insured (¼) and general revenues (¾).
Benefits financed by tax revenues, 1st full year.	\$2,300,000,000 ¹	\$560,000,000 based upon 80-percent participation. ¹	\$2,000,000,000 based upon 90-percent participation. ¹

¹ Benefit cost will also be offset by savings in other Federal programs and by increased Federal tax revenues. Total offset under combined programs in committee bill and under Republican program would be approximately the same—about \$300,000,000 to \$500,000,000.

In conclusion, Mr. Chairman, I shall vote to recommit this measure so that it can be improved by inclusion of the Republican substitute provisions for hospital care so that we can have a truly equitable and reasonable system in the United States, providing medical-surgical and hospital care for our elderly citizens. But if the motion to recommit fails, I must follow my conscience and vote "no."

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield 1 minute to the gentleman from Massachusetts [Mr. KEITH].

Mr. KEITH. I wanted to ask the gentleman a question. As I attended the Rules Committee hearings on this bill, the question of participation of State employees came up. As I understand it, retired State employees can be covered in their current status but there is only a reopening for a limited period of years for currently employed State employees. My question is: Can the currently employed State employees join in just the health portion of this program or must they join both?

Mr. MILLS. They would have to join the cash benefit program as well as the basic health benefit program.

Mr. KEITH. Thank you, Mr. Chair-

man. Mr. BYRNES of Wisconsin. Mr. Chairman, I yield 10 minutes to the gentleman from California [Mr. UTT].

(Mr. UTT asked and was given permission to revise and extend his remarks.)

Mr. UTT. Mr. Chairman, I take the floor at this time to place into the Record some of the reasons why I oppose the bill. I have no idea that I am going to influence anybody's vote, but I do believe the Record should be complete on some of the areas which I believe have been misrepresented.

I do not happen to be one of those who is dazzled by the great majority President Johnson obtained last November. It seems that when every bill comes up now it is referred to as a mandate of last November's election—the school bill, the medicare bill, the Appalachia bill, and I assume the voting bill.

I wish someone were wise enough to allocate the number of votes that belongs to each one of those programs. The President did carry about one-third of my district, I would say, and he carried it mainly because he was not going to put troops in South Vietnam. I should like to know the number of votes one might assign to the President for saying that Mr. Goldwater was "trigger happy" and

might bring on a war, and therefore, "if you don't want war, vote for me."

I remember that back in 1916, the slogan was to elect Mr. Wilson, "He kept us out of war."

I remember that 16 years later, someone said, "I hate war, and Eleanor hates war," so we elected another President, and almost before he was inaugurated again, we were in the middle of a big war.

Let us not attach all of the majority the President won in the last election to a mandate to pass social security amendments, medicare, school aid, and these other programs.

I believe we are advancing on three false assumptions.

First, in my estimation, we are saying here that everyone over 65 is a pauper and everyone under 65 is rolling in wealth. The young man on a payroll, working and putting his children through school, it is said, can take care of his medical expenses. He can dress his children, clothes them, and also make a great contribution toward paying medical costs of older people. That simply is not so.

A great number of people over 65 have their homes paid for. They have incomes. They are able to take care of their own medical expenses. We now

have a program to take care of the indigent.

So do not believe that all we are doing here is passing out benefits, because for every benefit we give, there is a tax. Do not forget that we will pass today a \$6 billion tax bill. Somebody will have to pay it. The man who has an income will pay and the man on a payroll will pay on a payroll tax. It is not all for free.

I can recall when we talked about a tax reduction and what a stimulant that was going to be to the country, to plow \$11 or \$12 billion back into the economy. Today, we are taking \$6 billion out of the economy again, and we will take it from one to give it to another. That does not create prosperity. It is class legislation. It is like taking water out of one bucket and putting it in another bucket and saying, "We have more water." We cannot do it. We do not create wealth and do not create prosperity by so doing.

This same committee will be before us next month seeking a reduction in excise taxes. I support it.

I have not voted in 12 years to continue the Korean excise taxes. I am for a reduction in them. But the great argument is that a \$2 billion cut in excise taxes will immediately help the economy. If a \$2 billion tax cut will help the economy, what will taking \$6 billion out of the economy do, except to cause a drag on the economy?

We are going on the assumption that this is not socialized medicine. Let me tell you here and now it is socialized medicine. Others are going to tell you that there will be intermediaries determining the costs and benefits to be given, and in no way is it socialized. The speaker just before me said that we are taking our first step today into the Great Society, which is the welfare state.

As we move on into the area of socialized medicine to the extent that Great Britain has today, the price tag will be in excess of \$22 billion for socialized medicine alone. That would mean a doubling of the tax rate which we have at the present time. Today that is so high that we are hearing rumblings and recommendations coming out of the White House to the effect that there should be a graduated social security tax and not a flat tax. Otherwise, give us a \$1,000 or \$2,000 deduction for the man in the low bracket or a man who has a family, give him exemptions for that, and immediately it would cause a skyrocketing of the base so that it would be paid for by those in the high income brackets.

I am supporting a motion to recommit on one ground and on that one ground only, namely, it leaves the practice of medicine in the private segment of our economy. The committee bill, with its hospitalization and supplemental insurance, puts it exactly into the public sector of our economy. There will be people who argue that that is not so, but let me tell you the difference between them. Under the committee bill they will go to your hospital and will say, "We are going to put our patients in there at cost." The profit system is

eliminated. It was the profit system which built America. They will go to hospital A and say, "What are your costs?" They will answer that they are so much per day. Then they will say, "Well, you have to eliminate your bad debt as part of cost. You have to eliminate your charity cases and shift the cost of taking care of older people onto the younger people." As a result there will be no profit and there will be a denial of the use of the best hospitals in America to these people. They will be forced to go to a nonprofit hospital. Let me tell you something about that now. The daily cost in a nonprofit hospital is oftentimes higher than it is in an efficiently operated hospital run for profit. So I think we should not eliminate profit. The Byrnes bill provides that you shall pay the reasonable going cost in the area.

Therefore you are allowed to make a profit. Profit is the only motivation for excellence. We are going to have a decline in the quality and the quantity of medicine in America. That is the thing which I oppose. I am not worried about the doctors. They are pretty smart boys and are able to take care of themselves. But when I have a child or a grandchild who needs some attention, I want him to have it now and not have to go on a long waiting list, just as they do in England where 200,000 or 300,000 people will be waiting 2 or 3 years before they can go to the hospital.

Since World War II under the system of socialized medicine in Great Britain there has been one hospital built. At the same time in America, with our private system of medicine, we have built 802 new hospitals. So, make your choice as to whether you want good quality medicine and good quantity of medicine or whether you are going to think you will get something for nothing, because if you think you are going to get something for nothing, you are not going to get anything which is very good. Let us not go on the assumption here that we are not destroying the quality and the quantity of medicine and that we are not socializing medicine, because that is exactly what we are doing.

Mr. Chairman, for those reasons I urge the support of the recommittal motion and the adoption of the Byrnes proposal and a final no vote if the Byrnes recommittal motion is not passed.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield 3 minutes to the gentleman from Indiana [Mr. ROUDEBUSH].

(Mr. ROUDEBUSH asked and was given permission to proceed out of order.)

THE LATE HON. MELVIN D. EDDY

Mr. ROUDEBUSH. Mr. Chairman, it is my sad duty today to report to the Members of this body that a very distinguished American has passed away.

I refer to Mr. Melvin D. Eddy, of Belmont, Mass., who was serving as National Commander of the Veterans of World War I, at the time of his death today in his home community.

I am sure that many Members of this body were well acquainted with Mr. Eddy, and are aware of the fine job he performed as national commander of the Veterans of World War I.

Mr. Eddy also was a member of the American Legion and the Veterans of Foreign Wars, two memberships he cherished very dearly.

I wish to express my sincerest condolences to Mr. Eddy's widow, Gertrude, and his 4 children, 1 stepchild, 19 grandchildren, and 2 great grandchildren.

Mr. Eddy, who would have been 68 years old this fall, was born on October 22, 1897, in North Harpersfield, N.Y.

He enlisted on May 17, 1917, in the U.S. Navy, at Albany, N.Y., and served aboard the U.S.S. *Pennsylvania*, and the U.S.S. *Canandaigua*.

His duty carried him overseas to Scotland, and he was engaged in mine laying activities from the North Sea to the English Channel, as our naval forces tried and succeeded in stemming the great German U-boat threat to our English allies, and our own shores.

Mr. Eddy was honorably discharged on January 22, 1918, as a yeoman, second class.

His present duties as National Commander of the Veterans of World War I, date back to his election on September 16, 1964.

Mr. Eddy, who became ill last December, had been a salesman for 15 years, and for the past 22 years before his recent retirement, he was associated with the Raytheon Co., of Newton and Waltham, Mass., as a machinist, toolmaker, and diemaker.

For the past 11 years he also was a precision inspector of machine parts.

Mr. Eddy's long service to his country and veteran's organizations dates back to 1919 when he became a member of the North Sea Mine Force Association.

Since 1956, Mr. Eddy had held elective and appointive office in the Veterans of World War I.

He had served this organization as barracks senior vice commander of his own barracks, up through the ranks to the position of top national leadership he held at the time of his death.

He also was a charter member and helped to organize the Belmont, Mass., Barracks No. 457, and served as his barracks commander in 1957.

He subsequently served as national aide-de-camp in 1957-58; senior vice commander of the department of Massachusetts, 1958; department commander, 1958-59; national legislative commission member, 1958-59; national legislative director, 1961-62; national junior vice commander, 1962-63, and national senior vice commander, 1963-64.

Mr. Chairman, we have lost a truly great American and a distinguished veteran. The loss of Commander Eddy will be felt.

Commander Eddy will be sorely missed. Thank you.

Mr. MORSE. Mr. Chairman, will the gentleman yield?

Mr. ROUDEBUSH. I am delighted to yield to the gentleman from Massachusetts.

Mr. MORSE. Mr. Chairman, I share the shock and grief of other Members of the House at the passing of Melvin D.

Eddy, National Commander of the Veterans of World War I.

As Deputy Administrator of Veterans Affairs and as a Member of Congress, I had frequent contacts with Mr. Eddy and found him always a gentleman, always concerned with the welfare of veterans of all wars. Although his primary activities were on behalf of the Veterans of World War I, Mr. Eddy was an active member of the American Legion and the Veterans of Foreign Wars.

Long active in Massachusetts veterans affairs, Mr. Eddy was a well-known figure and his untiring effort on behalf of veterans was known all over the Commonwealth.

I was proud to call Melvin Eddy my friend and I share the grief of his wife and family on this sad day. He leaves a noble legacy of public service that will not be forgotten.

(Mr. ROUDEBUSH asked and was given permission to revise and extend his remarks.)

Mr. MILLS. Mr. Chairman, I yield 10 minutes to the gentlewoman from Michigan. [Mrs. GRIFFITHS].

(Mrs. GRIFFITHS asked and was given permission to revise and extend her remarks.)

Mrs. GRIFFITHS. Mr. Chairman, on behalf of the Michigan delegation I would like to thank the Speaker for inviting the distinguished gentleman from Michigan [Mr. DINGELL] to preside over the Committee of the Whole during the consideration of this social security bill which includes medicare. The gentleman from Michigan is an ardent supporter of medicare as was his distinguished father before him. It is fitting that the son preside over the materialization of the father's dream.

On my own I would like to thank the gentleman from Arkansas [Mr. MILLS], the chairman of this committee, for his patient and painstaking effort to produce this excellent bill which far exceeds in benefits at this time the wildest hopes of the most devoted supporter of medicare.

This bill is no rubber stamp to the administration. It is a better bill than any administration ever supported. And yet, in my opinion, the benefit program is conservatively estimated. It has already been mentioned, but as a Member of the majority, I should like to express my gratitude also to the gentleman from Wisconsin, the ranking minority Member for this great assistance in the drafting of this bill.

It has been suggested that when this bill goes into effect hospital costs will rise. The answer is, Mr. Chairman, that whether this bill goes into effect or not hospital costs will rise and the tax levied in this bill anticipates that rise and provides for it.

At the present time hospital wages are less than 70 percent of the mean average of industrial wages. Hospitals, as you are aware, employ an unusually high percentage of women. Many of these, the nurses, the technicians, the dietitians, are some of the most highly skilled of all women. And now I want to make it absolutely clear that when I vote for this bill I hope these women do get a raise in their wages.

The average nurse today, working as a nurse, draws \$4,000 per year. She is not even drawing the social security base pay. A factory worker, a sweeper on his first day at work in the city of Detroit, makes more money than a trained nurse.

In addition, the factory sweeper in most plants is furnished with clean uniforms at the expense of the factory. In a hospital, insofar as I know, all doctors are furnished with clean uniforms. Most male orderlies are furnished with clean uniforms. However, few hospitals furnish clean uniforms to nurses.

Mr. Chairman, perhaps, this is why one-half of the trained nurses no longer practice their profession. As this bill goes into effect, it is time that the administrators of hospitals take cognizance of what industry has known for a long time; the better trained the work force, the lower the unit cost. That is, three ward orderlies do not really replace one trained nurse. They are merely more expensive.

Mr. Chairman, if this bill is effective it must employ the skilled services of women. In my judgment they should be paid in accordance with their skill.

Mr. Chairman, there is one other thing which I would like to mention in regard to women hospital employees. In this bill the Secretary of the Department of Health, Education, and Welfare is authorized to set up several advisory committees. I suggest that since women are going to have to do the work that the Secretary put some women on these committees and seek their advice at the policymaking level.

Mr. Chairman, I am for this bill. The increased cash benefit payment programs and the medical benefits, will in my opinion have a stimulating effect upon the economy. It is not necessary to reiterate that those people 65 and over seriously need the medical benefit part of this program. But, even if I were opposed on any grounds to the medical benefit program—and I assure you I am not—as a woman I would still consider supporting it.

Mr. Chairman, the medical benefit program is the second social security program that pays exactly the same benefits whether you are a man or a woman; that is, the woman does not receive one-half the benefits of her husband while he lives and 82 percent of his benefits when he dies. If you are a working wife, you are not permitted to choose between your rights as a worker or your rights as a wife or widow and select the greater benefit.

In this program, Mr. Chairman, you may be treated for different diseases, but whether you are a man or a woman worker, or a wife, a widow or a widower, the benefit period is exactly the same. It is unlike all other benefit programs but one. In all other programs the first question asked of a beneficiary is this: Is the claimant a man or a woman?

Mr. Chairman, I commend the chairman of the Committee on Ways and Means for his enlightened approach to this program and I heartily recommend that all other social security programs be hastily amended to provide benefits in the same manner.

The obstacle, of course, to the uniformity of the benefit payment has been created by time, the mores of our society and circumstance.

When the social security bill was first passed, approximately 21 percent of the labor force was female. Today it is 34.8 percent. Every young girl can now anticipate that she will work 25 years outside of her home. She will earn her own social security rights, but those rights are not as good as the rights earned by a man. Except for this medical program and one other program, the payment required to obtain her smaller benefit is the same payment that her male contemporary makes to secure a larger benefit.

Mr. Chairman, let me show the members of the committee how it works. Support Mr. X who is married to a non-working wife pays in on a \$4,800 base. At retirement he will draw \$127 and his wife will draw \$63.50, for a total of \$190.50.

Suppose Mr. Y has a working wife and each of them pays in on a \$2,400 base? Mrs. Y, because she works and pays into the program, can draw as a wife or a worker but not as both.

At retirement, although Mr. and Mrs. Y have paid in exactly the same amount of tax as Mr. X paid alone—both Mr. and Mrs. Y will draw \$84 each for a total of \$168 as opposed to a total of \$190.50 by Mr. and Mrs. X. And if Mr. X and Mr. Y die, Mrs. X, the nonworking wife, will draw \$105 and Mrs. Y, \$84.

It is worse if Mrs. X and Mrs. Y die. Mr. X will draw \$127 and Mr. Y, \$84. Obviously Mrs. Y is helping to subsidize Mrs. X. It is also obvious that the social security paid by the Y's should be added together, and they should be permitted to draw on that basis—this would cost the social security system \$1.8 billion annually.

For all of those lovers of means tests, I would like to show you now the meanest means test in the whole social-security program.

Supposing Mr. Y dies and Mrs. Y, after a period of mourning, and a quick look at that \$84 per month, decides to marry again. She marries a retired man drawing \$60 a month in veteran's pension. Naturally she assumes that since she is supplying one-half of the monthly income, her new husband will surely draw one-half of her social security. But she would be wrong. Social security will inquire into the whole circumstances and if by chance the new husband owned a house they could count the rent of that house at \$25 a month and deny him the social security; but if Mrs. Y dies and Mr. Y marries again, they will ask the new Mrs. Y one question: "Are you drawing social security as a worker?" If her answer is "No," she gets one-half the amount Mr. Y receives, even if she is as rich as Doris Duke.

The original theory of social security, of course, was that men work and support wives and families, but this is not true any more. Women comprise more than one-third of the working force. They support 10 percent of all families. The medical benefits program for the second time in social security history has

treated women as equals and pays exactly the same benefits to all, for which I am most grateful to the gentleman from Arkansas.

Wives have no vested right in social security, that is, originally in the social security setup, when a man died his widow was entitled to social security as long as she remained his widow. The moment she remarried she became somebody else's responsibility, and if he drew social security, after an appropriate time she drew as his wife. If he died and she did not have an established claim, she was out. This was corrected some time ago to permit her to return to her first husband's rights.

But a wife, married for 30 years to a man who paid into social security, and then divorced by him at a time too late to establish her own rights under social security, could not claim under the divorced husband. This bill to some extent corrects that situation—if they were married 20 years, and there is a decision of support, she can draw, or she can return to a dead first husband's rights.

There remain those people drawing social security and living in sin in racy Miami, who have discovered that the social security payment for a widow is greater than that for a wife—or that second marriages are penalized by reduced payments. The answer to this situation, it seems to me, is that payments should be on the total amount a couple pays into social security, and that the right of a wife should be as great as that of a widow.

These are problems that I feel will be solved by reexamination of the social security program in the light of the work experience and the need of beneficiaries of the last half of the 20th century, just as the medical benefits program has met that need in that reality.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield 15 minutes to the gentleman from Missouri [Mr. HALL].

(Mr. HALL asked and was given permission to revise and extend his remarks.)

Mr. HALL. Mr. Chairman, there are sweeteners in this bill and there are sweeteners in the hills of my home, the Ozarks. In logcabin days they used to keep a sweetening barrel by the door. One time a young man fell headfirst into the barrel and he came up licking his chops and said, "Oh, Lord, give me the tongue for this occasion."

I make the same prayer, today.

I come before you today as a physician—a member of the profession which is deeply and inextricably involved in the great issue before us.

Since coming to Congress, I have stood in the well of this House many times. Always, I have stood here in pride, and in appreciation for the honor bestowed on me by my fellow citizens who sent me here to represent them.

Whatever the matter before us on those occasions, I have searched with you for the answer to the one overriding question:

"What is best for the United States of America?"

That is the question we are striving to answer today. It is the spirit in which

I am speaking to you now. Our opinions may differ, it is true, but our aim is the same. It must always be so if the noble heritage of which we are the trustees, is to endure.

Today, perhaps more than any other, I am honored to be standing here. For I am speaking not only for my constituents but for my profession. I am speaking for a system of health care which is universally recognized as the finest in the world. As a physician, I could not have a greater opportunity or responsibility. As a Representative in Congress, one must be delving, perceptive, informed, and decide judiciously.

The members of the medical profession, of which I am one, believe we have a responsibility to call to the attention of the public—our patients—any projected development which threatens the quality of medicine in this country.

On us falls the ultimate responsibility for treating the sick, overcoming disease, and assuring that medicine's achievements of the last 25 years will continue and multiply to the benefit of all mankind. That has been our task through our professional lives; it will still be our task when the tumult and the shouting on this issue dies and Congress turns to other questions of the hour, expressed in the vast store of bills awaiting its consideration.

The question is not, as stated by one who preceded me in this so-called debate, the care of senior citizens, but how best to assure them needed quality care. I shall vote for the motion to recommit, and against final passage regardless of the sweetening.

We are the ones who will be expected to go on providing "only the best" of medical care, care tailored to fit individual needs, to which Americans are accustomed, and which they properly demand. In the last analysis, we are the ones who must contend directly with this program and try to make it work.

PHYSICIANS' ACTIVITIES UNDER H.R. 6875

Page 15, line 20: "(2) a physician certifies (and recertifies)."

Page 16, line 3: "(A) in the case of inpatient hospital services."

Page 16, line 10: "(B) in the case of inpatient tuberculosis."

Page 16, line 18: "(C) in the case of post-hospital extended care."

Page 17, line 8: "(D) in the case of post-hospital home health services."

Page 17, line 24: "(E) in the case of outpatient hospital diagnostic services."

Utilization Review Plan

Page 74, line 16: "For such review to be made by either (A) a staff committee composed of two or more physicians."

Page 75, line 10: "For notification to the attending physician of any finding by the physician members of (the committee) that any further stay in the institution is not medically necessary."

Consequently, we cannot stand idly by now, as the Nation is urged to embark on an ill-conceived adventure in Government medicine, the end of which no one can see, and from which the patient is certain to be the ultimate sufferer.

For make no mistake about it: The medical profession will never deprive the people of high-quality medical care and the fruits of progress of medical

science. That will come when the Government begins meddling and interfering with medical freedom.

What are some of the factors which, added together, clearly point to a deterioration of health care under a program of Government controlled medicine for any segment of the population? Let me list a few:

First. The basis for quality medical care is the voluntary relationship between the doctor and his patient. This would begin to disappear as the Government supplants the individual as the purchaser of health services.

An obvious attempt has been made in this legislation to conceal the grant of power which would be extended to the Secretary of Health, Education, and Welfare to interfere with administration and medical practice in participating hospitals. But the power is in the bill, and its use by Government employees in carrying out their responsibilities toward the expenditure of Government funds cannot be doubted.

The result would inescapably be third-party intrusion in the practice of medicine. The physician's judgment would be open to question by others not responsible for the patient's well-being. His diagnostic and therapeutic decisions would be subject to disapproval by those controlling the expenditure of tax money. Paradoxically, his cooperation is required for proper function and certainly to avoid the abuse factor.

Second. As the Government fixed prices for service rendered—as indeed it must to protect the public purse—financial incentive would begin to melt away.

Third. The incentive of competition with one's peers, invariably the spark which ignites the flame of creative progress, would also fade since rivalry would be eliminated by virtue of centralized direction, be it practice or all-important bedside research.

Fourth. As physicians and health facilities became more and more subject to intervention in their work by Government employees, a decline of professionalism would be certain.

Fifth. The overutilization and abuse of a "free" service to which everyone had a "right" would result in increasing physician harassment which could not fail to lead to a form of medicine abuse factor and had occupancy alien to these shores—medicine on an assembly-line basis.

Sixth. Quality medicine would be dealt a further blow by the loss of able entrants in the health field because young men, viewing a profession under partial or total Government domination, could be expected to seek careers in other fields.

These things will not happen tomorrow, or the day after, or next week, or next month. But as surely as the tides move tonight in Chesapeake Bay, they will come if this measure is enacted into law.

America today has the finest physicians and scientists in the world—a fact frequently demonstrated over the last decade when the Nobel Prizes have been handed out, or by your life expectancy, or by those seeking postgraduate training. These intelligent, highly trained,

superbly skilled men and women will continue to serve the health needs of the Nation, and because they are professionals, who have devoted their lives to this system of ours, they will continue to do the best they can, no matter what adverse conditions they are suddenly confronted with.

But what happens when this seed crop is gone? I suggest you look across the Atlantic for an answer. The other night I heard this sentence in a Chet Huntley broadcast discussing the current struggle between physicians and the Government in the British National Health Service:

Britain has been losing doctors at the rate of almost 500 a year. The number of medical students is declining, and already below the level of 1938. Meanwhile, the population grows.

You see, there are some things which cannot be handled by a law. Men bred in freedom learn to like the taste of it. Few engineers would want a government employee telling them how to draw a line. Most bookkeepers, I suspect, have little desire for advice from Washington on how to add a column of figures. I have yet to meet a lawyer who has spoken of his desire to have the legal profession brought under the surveillance of the Department of Justice.

It is as simple as that, gentlemen. This is not merely a controversy over whether Government should tax one group of citizens to provide health care benefits indiscriminately, regardless of need, to another group. This is not merely a disagreement over the best means of providing health care for our older citizens. Rather, this conflict is testing again whether the art and science of medicine will be permitted to grow and flourish in freedom, or whether progress in medicine will be stunted and shriveled by an excess of Government control, third-party interference.

Here let me nail down one of the most patent falsehoods that has been uttered by do-gooder proponents of H.R. 6675 in their campaign of abuse and vilification against the whipping-boy medical profession. This is the whispered charge that doctors are "really against the program because it would affect their income; that their fees would somehow be reduced by the Government."

Nothing could be further from reality. Doctors' incomes would probably be more assured, not less, if this bill is enacted. Anyone knows there is more money in mass production. It is principle, freedom, research, and insurers who will suffer.

Seventeen and a half million older citizens would become eligible for hospitalization, nursing home and home nursing care, financed from the Federal Treasury. Those lured to take advantage of the program by the prospect of a "free" benefit would need a physician's certificate to enter a hospital. Physicians would be expected to care for them while they were in hospitals or nursing homes. Who can say how many new patients physicians would acquire as a by-product of this legislation? It is safe to say the number would be sizable.

But that is really beside the point, or at least only a tangent. The American system of medicine is a system of quality medicine, not mass production or assembly-line medicine. It is a system of private medicine, practiced by private doctors treating private patients, free to make decisions based on the patient's specific medical needs and nothing else, except a confidential relation—privileged, if you please.

Forget for a moment the cost of staggering, though uncertain, proportions of the program before us. Ignore the administrative problems that it would create, and the burden it means for wage earners at the low end of the income scale. Neglect the new bureaus we are entailing.

Look only at the intrusion of Government in the field of medicine, which cannot be avoided, which goes hand in hand with this plan—the regimentation of hospital admission and discharges, arbitrary limitations on nursing homes available to care for aged patients, and the implicit responsibility placed on hospitals and physicians to keep the cost of this program under control.

Bureaucratic regulation cannot be mixed with medicine without diluting the quality of medical care anymore than gasoline and sugar in the modern combustion engine. In this case, furthermore, the availability of medical services to the aged would be governed by the availability of tax money, not by the medical needs of these citizens. If quantity is thus restricted, quality would inevitably suffer.

Under our system as we have always known it, treatment of the individual comes first, and financing second. It is the patient, in the role of the customer, that exacts the utmost from the doctor-patient relationship through his ability to choose freely.

The physician, in turn, responds to this show of confidence by the exercise of his knowledge and skill to his greatest capacity, guided solely by what is best for his patient.

This is not a public works project of stone and steel that we are dealing with, or the purchase of overcoats for the army. This is a fragile, perishable relationship, perhaps the most delicate in all human ties, and founded on American tradition and principle. It cannot withstand third-party tampering without serious harm. Are we to callously overthrow it by legislative process?

Standing here, I wish with all my heart I could get this point across to you. It is fundamental. Someday it will come back to haunt our memory.

Should the government become the customer—the outside party striving to reconcile the demands of the patient for high quality care and the demands of the taxpayers for efficient use of tax funds—the emphasis must shift from quality to cost. The government can resolve these conflicting demands in only one way. It must tighten the reins on services to keep them within budgetary limitations; either that, or the Department of Health Education and Welfare must be repeatedly pleadings with Con-

gress to ball out the program with higher payroll taxes.

We doctors want to continue to be free to give our patients the best advice and the best treatment we are capable of giving, without the pressure of outside considerations that have nothing to do with the quality of health care. We oppose any course of action which threatens the professional independence of the physician and imperils the wholly voluntary relationship which now exists between doctor and patient, thereby striking at the heart of our magnificent health care system which has accomplished so much for mankind in an atmosphere of freedom.

If this legislation is enacted, the aged would be the first to feel its effects on the quality of health care. But is it possible for health care to operate in one way for one segment of the population and in a different way for everyone else? The question answers itself. This is our first venture into providing service in lieu of cash benefits on a payroll deduction tax basis. What of the further effect of devalued dollars and inflation on these senior savers who secured their own future?

INFLATION ARGUMENTS

Mr. Chairman, for every action there is a reaction. This fundamental principle in Newton's law of gravity is no less true today.

The action we are about to take allegedly will provide Federal aid for persons over age 65. But at the same time this help is being offered, have we truly considered the ways in which we will be undercutting their ability to secure their own future?

The financing provisions of the administration bill involve a substantial increase in both the tax base and the tax rate, reaching 11.2 percent of payroll in a few years.

Every cent of this tax increase will come from employee and employer. As such every cent will be an increase in the cost of production of all goods and services in the United States. One does not have to be an economist to understand that every time you increase the cost of production you also increase the cost of the product.

The employer's contribution under this program is not going to come out of the pocket of the employer. It will come out of the pockets of those who buy his goods and services.

The employee's contribution under this program will come out of his own pocket, thus reducing his take home pay, and correspondingly reducing his purchasing power and further detracting from the value of his dollar.

It surely does not take an economist to know that the senior citizen and the younger citizen as well will, in 1966, when this bill becomes law, have to pay a little more for everything he buys including the very necessities of food, clothing, and shelter. How else could it be? The additional contributions from employers will be added to the cost of everything they produce.

The millions of older citizens who manage to live solely on their social se-

curity earnings, pensions or savings, are already in the poverty class if we go by the strict administration definition of poverty as being those who earn less than \$3,000. But the cost of everything they buy will go up when the cost of this bill becomes reflected in the rising price index.

Inflation is the cruelest tax of all, because it affects most drastically those living on fixed incomes, be it social security, or pensions, or private retirement programs.

Make no mistake. This bill, with its tremendous cost factors, will be inflationary.

Would that we were honest enough with ourselves to admit it.

This is no great humanitarian program, for it will not take a penny from the pockets of those who will take credit for it. None of our senior citizens in this body will contribute toward the program, at least insofar as their congressional salaries are concerned.

I wish, as this House acts on the bill before it, we were honest enough with ourselves to recognize that, as these new taxes take effect, it will raise the cost of every other vital need. And it will do it, not only to our senior citizens, but to our younger ones as well, including those just beginning to make their way in life.

Inflation and devaluation of saved-moneys are cruel and treacherous ways of dealing with an unsuspecting people.

If the quality of care for older citizens is lowered—under the pressure of over-use of facilities, of limitations on available funds, of physician harassment by outside intervention—it will be lowered for all.

Further, I believe it can be reasonably stated that consideration of this proposal cannot be limited to its merits or demerits as it would apply to a single group of citizens at the outset. We are aware that a former distinguished member of the House, Mr. Forand, has termed it a foot-in-the-door program.

The legislation as now written applies to all Americans aged 65 or older. But the minimum age for retirement is now 62. Does anyone seriously suggest that one of the first proposals after enactment of the bill would not be to reduce the age to 62 as a starter?

All the cost estimates and tax rates we are now trying to untangle would thereupon go out the window. Approximately 2 million more Americans between the ages of 62 and 65 would become eligible for benefits from the Federal treasury toward which they had paid little or nothing in taxes. Costs of the program would go up; the potential burden on our hospitals and other health care facilities would be measurably increased; controls would necessarily have to be tightened to guard against the added danger of saturation of these facilities by millions of persons seeking a "free" Government service to which they had a "right."

What is true of the legislation immediately, would be equally true as it expanded to include the rest of the population. What would begin as a "socialized medicine for the elderly," would become

"socialized medicine" for every man, woman, and child in the country.

At a time when American medicine leads the world, we are being asked to adopt a system under which one nation after another has lost its former leadership in medical science. We are urged to start down the same road that has been traveled by other countries whose health care today is marked by turmoil, bureaucratic controls, overburdened facilities, precarious financing, and distracted, frustrated doctors.

It would be impossible to believe if I were not here to see it.

One serious shortcoming in the bill approved in committee is that the abuse factor has not even been considered, much less, compensated for. Yet, we know now that this factor of abuse is what accounts for the severe crisis now confronting both the British and French systems of government medicine. Many more patients will be admitted to hospitals for diagnostic services under this bill, far more than ever before.

The bill apparently will depend on doctors to maintain hospital turnover, even though they will have less practical authority to carry out this responsibility, under the bill.

We all realize that the average length of hospital stay under this bill is certain to increase and the sum total will be that proportionately fewer and fewer private patients are going to be admitted as more hospital beds are occupied by persons eligible for free care under this bill.

Most certainly after this bill becomes effective, it will require a crash program of hospital construction under Hill-Burton, as well as another crash program of nursing and convalescent homes.

The \$64 question in most people's minds is bound to be, "will doctors participate?" Of course, it will take time to implement, and the answer will be partly determined by how this is done. A new fee schedule and sign-up of doctors who will participate will be a first order of business.

I predict that American physicians will sign up and participate because they are first of all humanitarians, imbued with the mission of serving people.

Perhaps the most incredible part of this whole operation, has been the utter disregard of the doctor's viewpoint by the social engineers who drafted this four-layer cake. This in spite of the fact that the program cannot possibly work without the cooperation of the doctors (13th amendment, neglected or voided in considerations.)

It might be compared to building a space satellite without engineers, or developing a battle plan without consulting the Joint Chiefs of Staff. I cannot help but wonder what Walter Reuther might say if the doctors should recommend that collective bargaining agreements be made up by business alone without consulting labor.

That is exactly what we have under this bill. Without the doctor, this bill is nothing more than 300 pages full of words signifying nothing. Yet, at no time during the week this bill was drafted, were the Nation's doctors asked to contribute to the deliberations or to comment upon the feasibility of the bill

insofar as they, their professional skill, and their ability and willingness to serve is concerned. This decision to ignore and even belittle the practicing physician whether it was made by President Lyndon Johnson, or Wilbur Cohen, or Mr. Celebrezze, or by the majority members of the Ways and Means Committee, will stand in the RECORD as the most brazen act of omission ever committed on a piece of major legislation. It will have its reverberations for as long as anyone of us is privileged to look into the future.

As one voice in this Chamber, as a physician whose lifetime of service in his profession has meant a very great deal to him, I can only ask you to pause and reflect and weigh this issue with prayerful consideration. It is not a simple matter. Of this, we are all aware.

But on balance, when you cast your vote, I hope you will be thinking of the next generation of Americans and all those who will come afterwards—and not so much about the next election.

I hope and pray, you will vote at least to recommit, on the least of two evils.

Mr. CAHILL. Mr. Chairman, will the gentleman yield?

Mr. HALL. I am delighted to yield.

Mr. CAHILL. This may not be precisely apropos of what the gentleman is discussing, but I know the gentleman is extremely qualified to answer this question. I, for one, and I am sure many of our colleagues in the House, are deeply concerned about the number of qualified young men and women of this country who are anxious to become physicians and who having scholastically qualified, find themselves unable to pursue their medical education because of the insufficient number of medical schools and the inadequacy of seats in those medical schools. At the very same time all of us recognize that there is in America today a great need for more doctors.

I am wondering if the gentleman can say to me what the medical profession is doing, or what the AMA is doing, what we are doing, to provide more medical facilities to get more medical doctors to take care of more Americans?

Mr. HALL. Yes, I think I can; and I appreciate the gentleman's asking the question. If the gentleman heard the first part of my remarks he knows about how we have maintained the doctor-patient ratio of approximately 1:750—1 physician to 750 patients—and certainly the gentleman knows that in this day of better communications and transportation you can get a patient to and adequate workshop—hospital, and so forth—under the care of a specialist more quickly than we used to be able to do it, in the days when we hitched up the shay and brought them into town where perhaps there were 5 doctors in some small community; and he can receive much better care.

As to the second part of the gentleman's question, I pointed out that the medical schools have been increasing in number, from 64 at the end of World War II to 85 at this time, and there are 9 more in process of building. They are all class A. There are no longer any substandard schools. And specifically

the AMA's Council on Medical Education is urging continued building.

Let me put the lie immediately to the bandied-about phrase that these schools are inadequate, or that the AMA is a strong organization that is preventing the erection of adequate numbers of new medical schools. The gentleman will recall that only last week I reported on a poll all over the country with reference to the preference that young people had for certain professions. They were: Supreme Court No. 1; physicians No. 2; politicians No. 11; and so on down the line. We are doing pretty well.

The fact is, in answer to the gentleman's question that a great number of fine young people at this time would like to become physicians, and under our private competitive system of medicine are applying at a ratio of about 15 for every vacancy in medical schools. But I deny that the output is inadequate for the projected need. General elementary and secondary educational classroom availability for 1960, for instance, was once estimated as being inadequate, but local school boards built adequately and so will local medical schools and universities. We do not legislate on "projected needs," they often care for themselves through local initiative.

Mr. CAHILL. Mr. Chairman, my point is that where there are 15 applicants who are qualified and only 1 of those 15 can be accepted in a field where admittedly there is an inadequacy of practitioners, does the gentleman feel we are doing enough?

Mr. HALL. I do not admit that there is an inadequacy of practitioners.

Mr. CAHILL. The gentleman does not admit that?

Mr. HALL. Not if we still have a ratio of one doctor to 750 patients that we had in 1950, with improved transportation and communications and the enhancement of facilities that we have developed, to say nothing of the ancillary aids such as better nursing.

Mr. CAHILL. Does the gentleman concede that some of our physicians today work less hours than some of our physicians used to?

Mr. HALL. I am sure a lot of them do, just as some Congressmen like to go home on Thursday night and not return until the following Tuesday. But this is not the whole medical profession.

Mr. CAHILL. Mr. Chairman, I think the gentleman is being not only completely irrelevant, but completely illogical, he is not answering my question.

But, the gentleman is being completely illogical when he refers to the Congress. The gentleman is not answering my question. I wish the gentleman would answer my question that I have asked.

Mr. HALL. I certainly do not concede that there are not enough physicians, and I do not believe that simply because there are 15 applicants for each vacancy that it necessary follows that this constitutes inadequacy. Actually, the point to be learned is that we will kill such initiative and selectivity, yes—even desire to serve people; if we legislate away our freedoms and competitive enterprise.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield such time as he may

consume to the gentleman from New Jersey [Mr. CAHILL].

(Mr. CAHILL asked and was given permission to revise and extend his remarks.)

Mr. CAHILL. Mr. Chairman, the gentleman from Missouri [Dr. HALL], has indicated in his remarks that the number of physicians in relation to the population has remained more or less constant. While this is a correct statement, the gentleman neglected to point out that the number of physicians in private practice per 1,000 has declined from 109 in 1950 to 97 in 1963. Expressed in another way—the relationship of family physicians to the potential patient load has changed from 1,300 patients per physician in 1950 to 1,700 patients per physician in 1960, and an estimated 2,000 patients per physician in 1970. Is this in actual practice constancy in the relationship of physicians to population?

I am sure that every Member of this House recognizes the need for medical care for the elderly and all of our citizens even though there may be some divergence in opinion as to the road to travel to obtain the objective. I would also say that with very few exceptions, every Member of this House would recognize the insufficiency of medical schools in the United States. I have been informed by accredited authorities that in the past 10 years, the output of medical schools has lagged behind the population growth and that in many areas it has only been because of the foreign-trained doctors that we have been able to maintain the performance in any degree in some of our larger hospitals.

Many of these foreign-trained doctors who are so desirable in many of our areas because of the acute shortage are graduates of schools which would not be accredited by the American Medical Association here in the United States.

For the gentleman from Missouri or any other Member of this House to say that we have sufficient medical schools and sufficient doctors is in my judgment a denial of the realities of everyday life. I am told that if we are to keep our present physician-patient ratio over the next 10 years, it is estimated that we must increase our medical school capacity by at least 50 percent.

In the year 1963, for example, approximately 55 percent of all qualified applicants to medical schools were enrolled. In other words, out of approximately 16,000 applicants, about 9,000 were accepted. This means that 7,000 young men and women of America who had a real desire and apparently were qualified were denied admission into medical schools. What is the reason?

Obviously there was no room for them in the medical schools. What does this point out? Clearly that we need 50 percent more medical schools than we have in the United States.

Why do we not have these medical schools? Why are we not training all of the young men and young women of America who want to be doctors? Why must we rely upon foreign-trained physicians to fill the needs of our communities? Why must we accept men to administer to our ill who attend foreign

medical schools which would not meet the requirements here in the United States as imposed on our medical schools by the medical societies?

I know from my personal experience a number of qualified and outstanding young men in my district who have been unable to get into a medical school. I have interviewed a score or more of these young men and can attest to their personal qualifications and their dedicated desire to join the medical profession in treating the illnesses of our society. It has been disheartening for me throughout my years in public life to point out repeatedly to qualified young men that there was, in fact, no real reason for their nonacceptance except the insufficiency of classrooms in our medical schools.

It is clear to me and I am sure it is clear to all Members of this House that with the population growth not only will the need be greater, but there will be an increase in the number of qualified applicants each year. My research indicates that in 1959 it was estimated that about 3,500 more medical school graduates would be needed by the year 1975. This would necessitate additional facilities equal in size to 35 medical schools of average size.

I would certainly express the hope today that the American Medical Society, instead of restricting the number of enrollees and the number of medical schools, would liberalize their programs and would take the leadership in America to bring new facilities into being and to provide new opportunities in the field of medicine for the youth of America.

It is difficult for me to understand why we in the Congress and why the men of medicine are expending so much money on medicine in space when some mothers are giving birth in this country unattended by qualified doctors, when some families are being subjected to pioneer medicine because of the unavailability of a physician in their community, when families in the dark of the night are unable because of the demands upon existing practitioners to obtain the services of a qualified physician.

I do not criticize nor condemn the doctors. I know that all of them are seriously and genuinely interested in caring for the physical needs of their communities. There is only so much, however, that one man can do. Doctors, like all other men, need time to spend with their families; need recreation and change; and require a certain amount of sleep.

The problem is not that the doctors are not doing their best. The problem is that their best is not enough with the demands upon them by the ever-increasing patient loads.

We do not need criticism for the doctors. We need more medical schools, more hospitals, and more doctors.

I find it difficult to understand why some plan is not conceived utilizing the existing collegiate educational facilities which abound in the United States. Why cannot young men and women start their medical career in the colleges of our country? Why is it necessary that they attend, at least for the theory part of their education, qualified medical schools in existence? It seems to me that many

of the subjects which constitute a medical curriculum can be taught just as effectively in an institution not associated with a hospital. Why cannot the theory be separated from the practice? Thus, if we were to train our medical students in institutions not associated with existing medical schools, we probably could, in a reasonable period of time, increase appreciably the number of physicians in the United States.

In my State, I am informed that we have 143 physicians for each 100,000 population; but that only 109 of these physicians are in private practice.

How many of us know personally men who have devoted a lifetime to medicine but who now, because of advanced age, personal illness, financial security, or some other personal reason, have found it possible, desirable, or necessary to devote only a part of their day and their week to the practice of medicine? How many of us know men of specialized skills in the field of medicine who take off an entire summer because their income is so high that our tax laws make it not worth their while financially on a year-round basis? How many of us know good doctors in their sixty's who, because of some personal physical reason, have restricted their practice to 3 or 4 days a week? How many of us know surgeons who operate only on a very limited basis? In other words while some statistics that have been asserted here today spell out a sufficiency in doctors, the fact remains that in actual practice we have a complete scarcity of doctors in almost every area of this country.

Let us remember in passing this needed legislation helping the aged of our country, that we cannot provide them with the proper medical care until we have a sufficient number of medical practitioners. Let us not forget that we cannot have a sufficient number of qualified doctors until we increase the number of our medical schools. Let us, therefore, here in the Congress of the United States, recognize that if we are to properly and adequately implement the program we are discussing today, we must do something in the immediate future to provide more medical schools to train more young Americans to become future doctors so that the aged and all citizens of this country can enjoy the type of medical service which they deserve and to which they are entitled.

I urge all of the Members of this House to examine the situation as it exists in their own congressional districts and then to take appropriate steps to urge the leaders of medicine of this country to join hands with the leaders of Government in this country to find a way to provide these much needed facilities at the earliest possible moment.

Mr. MILLS. Mr. Chairman, I yield 10 minutes to the gentleman from Virginia [Mr. JENNINGS].

(Mr. JENNINGS asked and was given permission to revise and extend his remarks.)

Mr. JENNINGS. Mr. Chairman, I speak today in strong support of H.R. 6675, the hospital insurance-social security amendment bill we are considering. This is a most significant piece of legislation, and I am proud to have been a

member of the Committee on Ways and Means that developed its provisions.

I commend and congratulate my chairman, the Honorable WILBUR D. MILLS, for his leadership in drafting this bill in committee, and upon his excellent presentation to the House. Chairman MILLS has again demonstrated his ability and wisdom in working toward committee approval of legislation needed by the Nation and desired by the people. I associate myself with his remarks in every respect.

The year of 1965 will count some notable events in the history of social security in America. Last January we completed 25 years of monthly social security payments. This month—April—the old-age, survivors, and disability insurance system will reach the mark of 20 million men, women, and children receiving benefits each month—more than 1 out of every 10 of our total population. In August we will be celebrating the 30th anniversary of the original Social Security Act. Even before this 30th anniversary, a fourth historic event will undoubtedly be entered on the record—the enactment of this social security-hospital insurance bill that has now come to the House for discussion.

I certainly feel that H.R. 6675 is among the major bills that have been debated during my tenure here. I rank it among the most far reaching of the bills we have considered to meet the needs of our people. The President has called it a "tremendous step forward" for our senior citizens. His special message on health benefits earlier this year was the beginning of our new effort to provide legislation of this nature. He said:

We can—and we must strive now to assure the availability of and accessibility to the best health care for all Americans, regardless of age or geography or economic status.

This legislation meets that goal. I would propose that my colleagues, who may question this bill in any respect, again read the President's message of last January. No more eloquent statement in support of the bill can be found.

Mr. Chairman, we can all visualize the need for this legislation on a national scale. The statistics are cited in our committee's report. However, I am certain that each of my colleagues daily receive letters from their constituents that more directly and dramatically reveal the need for approval of this bill and the hope with which it is viewed by millions of individuals.

I have not only had letters, but I have had dozens and dozens of conversations with my constituents—all outlining their needs and stating their only hope as being under social security.

These requests come from widows who can barely survive on their present benefits, and who deny themselves the hospital and medical care needed.

These requests from orphan children who await the ending of their benefits with fear and despair, and who would continue their educations if minimum funds could be provided.

These requests come from the retired and disabled who are caught in an economic situation where they cannot help themselves, and they find that help

from other sources is too often not available.

We decided 30 years ago, as the President has said, that our citizens' later years of life should "not be years of dependency and drift."

We adopted our social security program, which has been shaped and modified both by long-standing traditions and by changing economic and social conditions. We are making further changes today. And, they are all for the good.

Details of H.R. 6675 have been clearly and adequately presented by Chairman MILLS. I shall not repeat these. I wish to comment, however, on certain sections.

We have presented a coordinated approach for health insurance and medical care for the aged. It reflects the wish of the majority on the Ways and Means Committee to provide a program that meets the needs. There were several proposals before the committee and none of them really provided all that was desired. H.R. 6675 has utilized the best features of each.

The "basic" hospital insurance plan—the first of the three-layers in the proposed system—would be established for the aged and financed through the contributory social security system. Employees, employers, and the self-employed would pay the costs. It is estimated that more than 18 million persons would be eligible. This includes those receiving social security and railroad retirement benefits, and those persons not eligible for such benefits, but who would be covered under a special arrangement to pay costs from the Government's general revenues.

I have long stated that any program of hospital insurance under social security should be financed from a separate trust fund. This would provide the protection needed to maintain a sound system. We can see immediately where there were problems with financing. This has been provided in H.R. 6675. It is an excellent feature. An earmarked hospital tax would go into the separate hospital trust fund.

The second of the three layers in this program would provide a supplementary "voluntary" health insurance program for the aged to pay for physicians and related services not covered in the basic program. Again, it is soundly financed with the Government paying one-half and the persons electing to take this coverage paying one-half.

I am particularly pleased over the inclusion of coverage for hospital care in psychiatric and tuberculosis hospitals. I favored this provision and proposed it during the committee's actions. It meets a great need.

The third layer of the three-part health insurance program is the expanded and improved Kerr-Mills plan. This will assist the States in providing services for the medically indigent aged, blind, and disabled persons, dependent children and their parents. I hope the States accept their responsibilities and fully implement the revised plan.

There is a major section in the bill relating to expanded services for material and child health, crippled children, and

the mentally retarded, and to establish a 5-year program of special project grants to provide comprehensive health care and services for needy children of school or preschool age. Another section relates to the expansion of the programs of public assistance through increased Federal contributions and elimination of certain provisions in the law. Each of these features are excellent in their potential effects.

Mr. Chairman, I wish to turn now to the revisions that are proposed in the benefit and coverage provisions of the Federal old-age survivor's and disability insurance system. These are comprehensive and will meet many of the requests that have been presented to me through letters and personal conversations with my constituents.

We are providing a 7-percent across-the-board increase for those now receiving social security benefits or who will qualify in future years. This would be— if the bill is passed as reported—retroactive to January 1, 1965. The minimum increase per month would be \$4 for the individual and \$6 for a couple. An estimated 20 million persons would benefit from the increase this year. It is needed. It is deserved. It will make the lives of many people more enjoyable, because they will be able to afford a few more necessities for themselves and their families.

The bill provides for the continued payment of benefits to children after they reach the age of 18—until 22, if they remain in school. Children of deceased, retired, or disabled workers would be included. I have long advocated such a change in the basic law. Only this week two of my young constituents, who will soon be 18 and who wish to become nurses, wrote to me about the ending of their social security benefits when they become 18. They were concerned over the lack of opportunity to further their education and to make a contribution to our society as nurses. With this new provision in the law, plus assistance they might secure from the institution they elect to attend, they can reach their goal. This is among the best changes we have ever made in the basic coverage of the Social Security Act, and it is a monument to this 30th anniversary of the system.

The eligibility age for widows would be reduced from 62 to 60. Benefit payments for those electing the lower age would be actuarially reduced to compensate for the costs of this change. I regret this necessity, but it was clear the financial soundness of the whole program was involved. This will be helpful to an estimated 185,000 widows who are now in need of their benefits. Particularly, it will be helpful in areas of my district where coal mining has been the primary source of employment. Wives have become widows at lower ages due to the nature of their husband's employment. There is not always employment for widows in this area and the resulting need for benefits at a lower age is greater. I had hoped that even a lower eligibility age might be established for widows.

Another important feature of this bill is to provide benefits for persons 72 and over who have a very few quarters of

coverage. This is an excellent feature and will aid many of our senior citizens who otherwise would not be eligible.

These amendments to the social security program also provide important changes for the disabled. First, the present requirement that a worker's disability must be expected to result in death or to be of long-continued and indefinite duration is eliminated. We would provide that an insured worker would be eligible for disability benefits if he has been totally disabled throughout a continuous period of at least 6 calendar months. Second, the period during which an individual must be under a disability prior to entitlement to benefits is reduced by 1 month—from 6 to 5 months. These are important and helpful changes. There are several others in the bill which I shall not mention in these remarks.

This legislation makes two significant changes in coverage that have long been both advocated and opposed. Self-employed physicians would be covered. Employees who receive tips as a part of their income would be provided opportunity to have these tips counted for social security and tax purposes. This latter extension of coverage has created quite a controversy within the restaurant, hotel-motel industry. However, it is a needed change in the law and the procedures established would not work unjust hardship on the industry. The responsibility of reporting tips is placed upon the employee. If he does not act within a prescribed time, there is no obligation upon the employer. It is expected the employers affected can work these procedures into their normal payroll operations with a minimum of time and expense.

Mr. Chairman, we have a far-reaching bill before us today. It is soundly drafted and soundly financed. It meets the needs of our people in the best American traditions. It is not "unjust and dangerous" as described by the major national organization in opposition. It is modification of our social security system that has been warranted for several years.

We have spent months and weeks in consideration of all features of the program that is proposed. I urge its immediate passage.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield such time as he may consume to the gentleman from California [Mr. DON H. CLAUSEN].

Mr. DON H. CLAUSEN. Mr. Chairman, yesterday and today, the Members of this House have once again been granted the privilege of enjoying what I consider to be the "greatest show on earth." I say this with an affectionate tone of respect for the chairman and all members of the Ways and Means Committee as they present their point of view on the legislation before us, H.R. 6675 by the gentleman from Arkansas [Mr. MILLS] and H.R. 7057, by the gentleman from Wisconsin [Mr. BYRNES], the alternative to be presented to the Committee in the motion to recommit.

It is interesting to note that H.R. 1, the original King-Anderson proposal of the administration, has for the greatest part been abolished by the Ways and Means Committee and we have before us now

what most appropriately might be called the Mills-Byrnes bill, due to their lead roles in drafting this legislation.

Also, it is somewhat ironic that for all practical purposes the benefits under the two proposals are almost identically the same, leaving the major issue before us on just how the program of benefits are to be financed.

So it can rightfully be said, this is a great day for the old folks, particularly those in need of medical and hospital care, but it can also be said that it's a sad day for the young folks. Herein lies the major points that divide the Members on this issue. I believe it would be helpful to once again spell out the basic differences between the two bills.

H.R. 7057 contains all of the amendments to the social security laws that are contained in H.R. 6675 except for parts 1 and 2 of title I, which contain the hospitalization program financed under social security, the program for voluntary supplemental medical insurance and the additional payroll tax to finance the hospital program.

For parts 1 and 2, H.R. 7057 substitutes a comprehensive program of health insurance for the aged that is financed partly by premium contributions and partly by the general revenues. In addition, H.R. 7057 makes even more specific the authority of the State to use and implement the eldercare approach. The States are specifically authorized to set up private health insurance programs for the aged.

At this point, I want to specifically go on record as being in support of the Byrnes proposal, H.R. 7057, and will cast my vote accordingly.

Further, I want to commend the committee and record my support in favor of the 7-percent increase in cash benefits for social security recipients, the extension of benefits for widows with children in college to age 22, and permission for some to increase their earning limitations. Incidentally, I believe this could have been broadened to permit those who do not qualify for maximum benefits to earn, in addition to the existing \$1,200 annual income, an amount equal to the difference between their current social security payment and the maximum benefit paid to those who qualify as fully insured. Last year I introduced a bill to accomplish this and while I am pleased with the committee's inclusion of this approach in the bill, I do not believe they have gone far enough. Were it not for the restriction of the closed rule on this bill, I would have asked that the contents of my bill be amended into this act. This would permit those not receiving maximum benefits to supplement their earnings without jeopardizing or losing their social security payments.

With my position firmly recorded on what I am supporting today, I would now like to direct a few remarks on why I support the general revenue method of finance rather than the increase in payroll tax approach.

When I said it was a great day for the old folks and a sad day for the young folks, I really believe this to be the case, with one possible exception—if I know senior citizens, I think they are a very

proud lot. I firmly believe they have a burning desire to maintain their dignity and self-respect in their twilight years. The Byrnes health care proposal gives these wonderful people the chance to retain their pride by participating in the premium payment to the best of their ability. The balance will be paid from general revenues collected from all the people of the United States. This concept, I might add, is very similar to the proposal made by Senator RIBICOFF, the former Secretary of Health, Education, and Welfare in the Kennedy administration.

There is no doubt in my mind that the upward spiraling costs of hospital and medical care plus the inflationary fiscal policies of the Federal Government have created a health and financial crisis for our elder citizens on fixed incomes and pensions. It is our obligation to help them out of this dilemma. The burden for a solution to this problem must be the responsibility of this entire Nation and its total tax base—not just be placed on the shoulders of our lower-income wage earners. These people can least afford it because of the continuing increases projected for cost of living, education, and other personal family responsibilities.

Yes, it is a sad day when we legislate a program that takes away the dignity and self-respect of our revered senior citizens and heap an increasing burden on the young wage earner who has to struggle now to keep his head above water financially. It is a sad day because an alternate plan is available but this young man and woman will not have the chance to vote on it. He is forced to accept this whether he likes it or not. I wonder if he has been told what financial burdens are being voted on his shoulders this week. I wonder what his reaction would be if he were told the truth—the whole story.

What is the whole story? My able friend, the gentleman from Illinois [Mr. COLLIER], a member of the Ways and Means Committee, has advised the current annual cost to workers and employers of \$174 each will increase in 5 years to \$316 each under this new payroll tax. How much of a load can one carry? And this is compulsory—he has no choice—you have practically eliminated the freedom of choice under this system of compulsory health care. If one is not satisfied, where is his recourse? The self-employed and the small businessman are really hit the hardest. This is just one more burden for the person doing his best to take care of himself or expand his business to create jobs.

The costs will continue to rise and the problems of administration will increase. Further, I will predict that each Congressman's mail over the next decade will increase tenfold as he finds himself in the position of claims adjuster for disillusioned and dissatisfied constituents.

There is a substantial difference between administering a program to provide cash benefits under social security and the administrative requirements for hospital service and medical care. In the case of cash benefits for social secu-

rity recipients, you are dealing with known factors. The amount prescribed by the social security law is paid under clearly defined provisions when the insured either reaches the established retirement age—65 and 62, unless disabled—or he or she dies. It is comparatively simple for the actuary to be consistent in his cost estimates of this program because of existing mortality tables to compute the average life span beyond 65, both for the annuitant or his beneficiary. But yet under the best circumstances heretofore described, we all know the history of demands for increased benefits and costs as inflation has cut into the purchasing power of the dollar and the cost of living has gone up. And now in both of these proposals we quite properly have up for approval the 7-percent increase in cash benefits to further substantiate this point.

With some of the problems associated with comparatively stable factors, just imagine what we are going to have when we add the many variable factors if the administration of hospital service and medical care programs is placed with the Social Security Administration. Again, Mr. Congressman, do not complain as the mail from disenchanted constituents increases in your office.

Early in the year, I met with members of the Ways and Means Committee individually to discuss and present what I thought to be an adequate guideline of objectives and recommendations for a comprehensive health insurance plan for all persons 65 and older:

A plan designed to pool the financial resources of the public and private sector and direct them toward the creation of a program providing the maximum range of benefits—a plan that could ultimately be integrated with existing private individual and group hospital service and insurance programs—a plan that would someday see all American citizens covered by a maximum of benefits at the lowest possible cost because of the mass market created by this integrated insurance concept—a plan that would guarantee the same freedom of choice in the selection of your doctor, your hospital and your insurance carrier—a plan designed to minimize the duplications in our multiplicity of overlapping Government programs.

For the RECORD and the benefit of my colleagues, I would like to present a copy of my projection as presented and circularized on January 5, 1965. In particular, I would like to draw your attention to the comparability of this guideline to the proposals before us today:

Advances in medical care which extend life and increase the cost of health maintenance make it increasingly difficult for the elderly to finance their own medical care, in spite of a significant improvements in their general economic status. Although presently available plans have taken a great step in the proper direction, new methods are needed to assist this group.

I propose a legislative program whereby a comprehensive health insurance plan would be made available to all persons 65 or older, regardless of income.

(a) For those of restricted income, Government would reimburse all or part of the costs of the plan. The amount of reimburse-

ment would be determined on a sliding scale according to the individual's ability to pay, based on income tax information supplied by the individual and verified by a Government body.

(b) Those of adequate income could purchase the same comprehensive plan at the lowest possible cost, because of the mass market created by Government participation and the efficiency of the existing private health industry.

The insurance plans would be written by private insurance carriers and other private purveyors of medical care. It is the intent that broad and comprehensive, though practical, definitions of total medical care be used and that acceptable plans cover a minimum of 80 percent of total expenses as defined in the "Components of an Adequate Health Insurance Program" of the State medical associations. Some element of co-insurance by the insuree, whenever he is financially able, would be desirable in order to avoid overutilization. Total medical coverage should be provided when necessary by the responsible agencies of Government by supplementing the basic insurance benefits with the use of existing health plans and facilities and/or by the purchase of additional insurance.

The moneys for this program would come from Federal, State, and county general tax funds. There would be Federal reimbursement to State governments on a matching ratio basis according to each State's ability to pay based on the per capita income of that State.

Local medical review committees would be established and charged with the responsibility for maintaining high-quality medical care. Such review committees would review claims and thus prevent abuse and overuse of services by both the purveyors of medical care and the insurees.

Regional boards with adequate representation from the health industry, Government and consumer, would be established and charged with the responsibility of determining the economic value of medical services. The regions would be as large as possible and as small as necessary to recognize the geographic variations that occur in the cost of medical care. In those areas where relative value scales are used the board would ascertain and utilize the prevailing conversion unit. In those areas where the relative value scale is not in use, usual, customary and reasonable fees would prevail. In such areas the board would be advisory to the insurance industry to insure that medical expenses are proper. There would be provision that at regular intervals the regional boards would review the remunerations for medical services and keep them current.

It is suggested that if the principles embodied herein are adopted this type of program might serve as a substitute for some existing health care programs and as a model for future Government participation should such need arise.

In closing, Mr. Chairman, I urge the Members to carefully weigh the factors presented—vote independently on the plans before us. Again, the prime issue before us is not the benefits proposed in the bill—we are in general agreement on this—but it is a question of whether we want to vote for what amounts to a gross income tax increase on those who can least afford it. To take more money out of the pockets of our working people, to pay for a problem they did not specifically create, is not only unfair but is counter to the basic concepts of sound financing under our private enterprise system.

One final thought—I personally advocate the implementation of a tax structure revision that would provide more incentives and tax credits for people, employees, employers, self-employed alike desirous of providing for their own hospital and medical needs or that of a friend or relative. This would motivate the volunteer participation of our people—it would strengthen our voluntary health programs instead of destroying them. This type of effort could conceivably “show the way” in establishing medical and hospital protection programs for the balance of the free world to follow—designed to provide the security and peace of mind as well as the feeling of satisfaction and pride that accompanies that well-known expression, “The ability to stand on your own two feet.” This objective can only be accomplished by taking advantage of the choices offered through our private enterprise system—an objective designed to preserve the dignity and self-respect of our senior citizens—an objective designed to create incentives for future generations to become self-sufficient in their own right and less dependent upon a Federal bureaucracy. This is the American way.

With this in mind, I urge you to reject the payroll tax increase and adopt the general fund method of finance as recommended by the gentleman from Wisconsin [Mr. BYRNES], by adopting his motion to recommit. The committee has accepted most of our recommendations, now let us complete the job and make this a great day for all the American people.

(Mr. DON H. CLAUSEN asked and was given permission to revise and extend his remarks.)

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield 5 minutes to the gentleman from Ohio [Mr. BOW].

(Mr. BOW asked and was given permission to revise and extend his remarks.)

Mr. BOW. Mr. Chairman, for more than 3 years I have insisted that the health needs of our retired citizens demand a program of hospitalization and medical services under Federal sponsorship to protect them against the mounting costs of prolonged or very severe illness. I have done everything in my power to convince the medical profession and my Republican colleagues that Kerr-Mills was not enough and something more must be done. I have believed it imperative to rescue large numbers of middle and lower income senior citizens from the threat of indigence caused by the expenses of modern medical care.

H.R. 21, my medical care insurance bill, was the first and for a long time the only House Republican proposal to solve this problem. I continue to believe it is the best, the most simple and the most certain solution. If I could have convinced my medical friends of the inevitability of health care legislation and if I could have obtained their support for my proposal, I believe it could have been enacted into law.

The pending bill requires me to make a very difficult decision. Although I have long recognized and spoken out about the

need for action, I have also been one of the most outspoken critics of a program financed by social security taxes and administered by that agency. I still believe this is a serious defect and that in the long run it will prove inefficient and cause much unhappiness.

The question I have had to decide is whether the inclusion of the social security basic hospital plan in this bill should outweigh all of the meritorious features of the bill for which the Republican members of the House Ways and Means Committee are largely responsible. I refer specifically to the voluntary major medical plan which is so similar in many respects to my own bill; the badly needed increase in social security retirement benefits, and the other adjustments in the Social Security Act that I have personally advocated, including the much-needed extension of a child's benefits.

My conclusion is that the good in the bill outweighs the bad. After years of talking about health care for the aged, the time has come to take action. To wait for a bill that is perfect would be an injustice to millions of our elderly citizens for whom the problem becomes more pressing every day. I cannot place myself in the position of opposing this solution to their problems simply because my own solution has not been adopted. I will vote for the bill.

Experience has shown that every new Federal program has its imperfections. We are assuming here today a heavy responsibility to follow the development of this medical care program very carefully and to make certain that it does solve the problem without bringing about Government-controlled medicine. If experience shows that it is either too costly a burden on wage earners and the self-employed or that it is too cumbersome and restrictive in its administration, I will again press for consideration of a comprehensive voluntary hospital insurance program based on the principles of H.R. 21—the Bow bill.

Mr. BYRNES of Wisconsin. Mr. Chairman, will the gentleman yield?

Mr. BOW. I will be delighted to yield to the gentleman from Wisconsin.

Mr. BYRNES of Wisconsin. I think that the gentleman from Ohio [Mr. Bow] deserves a great deal of credit from all Members of the House for the interest and the work he has done and the concern that he has shown in the problem which our aged face as far as their medical needs are concerned. Certainly as one member of the committee and of the House, I want to voice my great appreciation for the work he has done and the interest he has shown.

Mr. BOW. I thank the gentleman from Wisconsin.

Mr. MILLS. Mr. Chairman, will the gentleman yield?

Mr. BOW. Yes. I am glad to yield to the chairman.

Mr. MILLS. Mr. Chairman, I would like to join my friend from Wisconsin in also calling attention to the contribution that the gentleman from Ohio [Mr. Bow] has made to a solution of the problem that we are facing and trying to solve here today. The gentleman

from Ohio has talked to me on numerous occasions about his feeling that something additional ought to be done and that we had not up to this point adequately resolved this problem. He has taken the lead in the introduction of such legislation on his own. I want to commend the gentleman not only for this background of constructive effort on his part, but I want to congratulate him also for what he has said on the floor here today.

Mr. BOW. I thank the gentleman, the chairman of the committee.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield 13 minutes to the gentleman from Montana [Mr. BATTIN], a member of the committee.

(Mr. BATTIN asked and was given permission to revise and extend his remarks.)

Mr. BATTIN. Mr. Chairman, certainly, as probably the newest member of the Committee on Ways and Means, I would be very remiss if I did not say a special thank you to the chairman of the committee, for whom I have high regard, and to our ranking Member, the gentleman from Wisconsin [Mr. BYRNES]. Actually the programs that will be considered here today are more than complicated. As a matter of fact, there are several issues involved. Some have been discussed and some are completely new concepts, and from the dialog which has developed in the country thus far are not fully understood. It was a week or so ago in the local newspapers here in the District of Columbia that an editorial discussed the fact that the bill was so comprehensive that it should be fully debated and full hearings should be held.

As a new member of the Ways and Means Committee I have not had the opportunity to participate in hearings over a number of years as have some of my colleagues. I voted at the outset of hearings on H.R. 1, the forerunner of H.R. 6675, to hold open hearings so interested people both for and against the legislation could express themselves on the King-Anderson bill, the Byrnes bill and the Herlong-Curtis bill. The working press of the country could then have advised the people of all 50 States on what the proposals were, the arguments for and against, and then we as representatives of the people could have had an expression from our constituents on their thinking.

The reaction in committee was that no public hearings were necessary—full speed ahead. And ahead we went, running into one pitfall after another, changing section after section, rewriting the bill, adopting parts of eldercare and the Byrnes bill and keeping the compulsory features of social security.

By the end of some 7 weeks, if other Members felt as I did, they would have come to the conclusion that we perhaps had had a dose of our own medicine. A bill has been reported that can properly be described as a conglomeration of thought, ideas, and, of course, some compromise. It is part compulsory, part voluntary, part permissive. It covers, for the most part, the entire field of med-

ical and hospital care. It puts the great insurance industry of the country into a "cocked hat" position. What is not covered by this bill probably will not be covered by private insurance because of the cost factors involved.

What I am trying to express is the confusion that prevails, at least in my mind, and I am sure in the minds of others. No one in this House, I am sure, wants to do harm or violence to our hospitals, doctors or insurance companies. We have an obligation to meet a need that exists in the country.

The high cost of medical care both for hospital and doctor has its effects on the person over 65 and who because of retirement lives on a fixed income. We could better help the senior citizen by attacking the problem at its core. The passage of this bill, like the passage of pay increase bills for Federal employees and military personnel, the increase in cash benefits to those on social security and other measures only administer the medicine and are not designed to attack the disease. They in no way attack the problem at its core. For some reason we continue to overlook the basic problem.

Let me use an example. A married couple in 1939 were talking about retiring in 1954—some 15 years later. They were covered by social security and would have an annuity from the company the husband worked for payable on retirement. They would have the house they lived in paid in full, their children would be grown, educated and probably married. Who could ask for a brighter future?

The World War II intervened and the country went into an inflationary spiral. After the war and in 1954 the husband died and his widow, my mother, still lives. The money from social security and other income planned for in 1939 has been so eaten up by inflation that the wonderful feeling of security evaporates.

Those who have earned and paid their way now suffer the inflation caused by unbalanced budgets and are convinced of the fallacy of the economists who proudly proclaim we have no debt for we owe it to ourselves.

One of our colleagues yesterday on the floor read from history some of the positions the Republicans had taken in the past on social security, and I was intrigued, because if he believes so much of what was said in the past maybe we should read some more. On January 5, 1939, a budget message to Congress from Franklin Delano Roosevelt, read in part—I am sure you all know it and remember it well:

The ordinary expenses of Government should continue to be met out of current revenues.

But I also hope that these revenues in time of prosperity will provide a supply which can be applied against the public debt which the Government must incur in lean years because of the extraordinary demands upon it.

Mr. Chairman, I wonder if that is the approach that is going to be applied, or maybe the approach of Harry Hopkins when he said that he believed in "tax, tax, spend, spend, elect, elect."

If we in Congress could sit down at the collective bargaining table and represent those on fixed retirement income, the senior citizen, we could win no better concession than to stabilize the purchasing power of the dollar, and this can only be done by following the procedures of a balanced budget, a reduction of our national debt, and a complete repudiation of those who think we can spend ourselves rich.

The hospitals raise prices because they are required to stay in the business of caring for the sick. Doctors compete in the same society and are entitled to raise their charges as cost pressures apply to them, and yes, we should never criticize our senior citizens for wanting protection, because they are caught in the mousetrap of Government spending and can do little to protect their investments.

We will continue to pass legislation to increase spending on all fronts so long as we keep on the merry-go-round of inflation.

The tax increase built into this bill will also have its effect on the present generation and future generations of workers, for they are going to pay heavily on their gross incomes to finance the cost of this and future programs. It is particularly bad, because they need the money now to raise a family. Yet we have the planners among us who sincerely believe that all real necessities can and should be provided by Government.

Now I do not want to be misunderstood. I labor under no delusions that my remarks today are going to sway anyone or change a vote. I am sure the press releases are already placing a great additional burden on the Post Office Department advising the people at home that their problems are now taken care of and no new worries can be foreseen. I wish we were right, but we are not. We are not even close.

Taking conditions as they are, most features of the bill are good and very helpful. Certainly those on the Republican side have long advocated many of the changes incorporated in the bill. Unfortunately, we are not permitted to vote on the merit of each change in the law. We have a choice of voting the bill up or down, taking all or nothing. Some will say that anyone who votes against the bill is against the senior citizen. Yet if someone on the Republican side votes for the bill these same people will question their motives and intentions. I have no doubts that a bill will pass and I hope that all who are interested in the full medical needs of the senior citizen will follow the debate and pay particular attention to the gentleman from Wisconsin [Mr. BYRNES], when he further discusses the motion to recommit. It was the Honorable Wilbur Cohen, Assistant Secretary of HEW, who said the Byrnes proposal was as comprehensive a program of medical care as offered by any insurance company today. And it was Mr. Robert Myers, the chief actuary for the Social Security Administration who estimated that at least 90 percent of the people over 65 would subscribe to this voluntary comprehensive medical coverage.

The insurance approach used by Congressman BYRNES is patterned after the

Government employees high option policy we make available to Government employees. We should do no less for our senior citizen. We should vote for the motion to recommit so we can pass a better bill. It might even be such a good bill that the other body can just accept it without a lot of extra work. It will not place upon today's worker the regressive payroll tax. It will be more comprehensive and, yes, even though it has been questioned it will give more services at less cost than H.R. 6675.

Mr. KEITH. Mr. Chairman, will the gentleman yield?

Mr. BATTIN. I yield to the gentleman from Massachusetts.

Mr. KEITH. I am very much interested in this program, and have been for some time. In particular have I been of the opinion that the social security approach was the best way to provide the platform for the hospital care in this legislation. I would like to ask, with reference to the supplemental services provided by the doctor or surgeon, would the gentleman not think it would be more advisable for insurance companies to do this independently of the Government by issuing a policy for \$6, \$8 or \$10 a month covering the doctors' and surgeons' fees above the hospital?

Mr. BATTIN. And have that as a part of the program?

Mr. KEITH. No, just above the basic plan, the so-called King-Anderson plan, or the President's original plan, and leave the rest of it to the insurance industry to fill a gap at a cost of approximately \$10 a month?

Mr. BATTIN. I am sure the gentleman knows my opinion. The insurance companies have done an excellent job. I wish the gentleman from Missouri [Mr. CURTIS], had gone into the number of people today that are covered, by private medical plans. Is the gentleman suggesting that the program he mentioned also be financed from the general fund?

Mr. KEITH. I am suggesting that the legislation would have been better had it had solely the social security package that was proposed historically by the King-Anderson and Forand bills.

The CHAIRMAN. The time of the gentleman from Montana has expired.

Mr. MILLS. Mr. Chairman, I yield 10 minutes to the gentleman from Illinois [Mr. ROSTENKOWSKI].

[Mr. ROSTENKOWSKI asked and was given permission to revise and extend his remarks.]

Mr. ROSTENKOWSKI. Mr. Chairman, I strongly support H.R. 6675 and urge my colleagues to do likewise.

This legislation will be of inestimable benefit to the citizens of our Nation and to our economy, both individually and collectively. As one of those who has been urging enactment of legislation providing for many of the changes which are embodied in this bill, I should like to commend the chairman of the Committee on Ways and Means for his brilliant leadership in developing H.R. 6675. This bill will not only mark the beginning of a new era in our social security program by providing medical care for the aged, but also contains tremendous improvements in the existing cash benefits program.

In the some 30 years since the social security program was enacted, it has become the principal source of income for nearly every American family when the wage earner's income is cut off by old age, disability, or death. Because so many of our people depend upon this program for their continued economic well-being and peace of mind, it is necessary that it be kept current with the changing times and in tune with changing economic conditions.

As a member of the Committee on Ways and Means, I am proud to state to the membership that the committee has explored in a most painstaking manner every major facet of this legislation and I can assure the membership that the bill is actually sound and fully financed. This is in accord with the tradition which the Committee on Ways and Means has established over the years.

Mr. Chairman, so much was said yesterday in debate about the method of financing the committee bill as compared to the so-called Byrnes substitute that I feel constrained to nail down several issues which I think are very crucial. First, let us make it clear exactly how the committee bill is financed.

The "basic" hospital program is financed through a separate payroll tax with a separate trust fund. The "supplemental" benefits are financed by a contribution from individuals matched by a contribution in equal amount from the general funds. Now why would we provide a payroll type of financing for the "basic" hospitalization program? It is quite simple, Mr. Chairman. We did so because this is the most expensive part of the program and because payroll financing is the most conservative approach which could possibly be adopted. It is conservative because the benefits cannot be increased without a consideration at the same time by the same committee of the Congress of the cost of any increase in benefits. Therefore, benefits are tied directly to cost and must necessarily be related to cost and must necessarily be considered at the same time that cost is considered. Those of us who have been in the Congress even for just a few years recognize how easy it is when general fund financing is used for a program to increase authorizations through one committee and then obtain appropriations from another committee. This type of operation cannot take place with regard to the basic hospital program envisioned in this bill.

It has been the history of the Committee on Ways and Means in the case of every benefit increase, with regard to the cash benefit program, that tax rate increases are provided in the same legislation at the same time. I am confident this would not have been true had the cash benefits been financed out of the general funds. Fiscal control is much greater over any system where the financing and the benefits are within the jurisdiction of the same committee of the Congress.

In addition to the social security trust fund from which social security cash benefits are paid, we also have another example of the manner in which trust funds and dedicated taxes provide fiscal

control; namely, the highway trust fund. In 1956, when the greatly expanded highway program was enacted, a special trust fund was created out of which the expanded highway program had to be financed. On several occasions, because of the increase in costs due to inflation, and so forth, and because of additions to the Interstate System, the Committee on Ways and Means has reviewed the financing and has provided increased funds for the trust fund. I am confident if we had not created such a trust fund, there would not have been the additional financing provided at the time when the costs increased but on the contrary, we would simply have created a much greater deficit in the general funds of the Treasury thus increasing the public debt and deficit financing. The conservative way to finance the most costly part of this medical care program is to do so by the payroll and trust fund method. It is ideally suited for this type of program. It will enable us to keep our eye constantly on the costs. It will prevent unsound expansion. It will foreclose the addition of extravagant benefits unaccompanied by the funds with which to pay for them.

Returning now, Mr. Chairman, to the impact of the bill, the cash benefits not only affect the people who receive these benefits directly but, because they are spent on the necessities of life, they are of direct benefit to the merchants and businesses in the communities where these beneficiaries live. In addition to that, the hospital and health insurance provisions in this bill will release funds that the aged citizens of our country have not felt free to spend because of the threat of costly illness. The 19 million aged Americans over age 65 will have basic hospital insurance assured and have the opportunity to enroll voluntarily in a plan providing supplemental health insurance. Safeguards have been included so that there can be no interference in the practice of medicine.

H.R. 6675 is a milestone in the history of social legislation. The impact of the improvements made by this bill will be felt for many years to come. One million people not now getting benefits will become eligible for monthly benefits. Twenty million people who now get benefits will have their benefits increased. Many thousands in the State of Illinois and the city of Chicago will benefit directly. The across-the-board increase along with the basic social security hospital insurance and the voluntary supplemental health insurance will be worth \$20 a month to the average retired worker, and \$36 a month to the married worker whose wife is age 65. Many thousands of children in Illinois and in the city of Chicago will be able to complete their education by virtue of the provision in the bill continuing child's benefits to age 22 while in school.

The changes provided for by H.R. 6675 make the social security system more flexible and, as a result, more responsive to the economic needs of our citizens. Mr. Chairman, I believe this program to be one of the important stabilizers in our economy, and I believe that the ac-

tion we are taking now undoubtedly will help prolong the present prosperity.

While H.R. 6675 will make a significant contribution to our Nation's economy, we should not overlook for a minute the longrun effect that this bill will have. I point out the economic benefits as only another favorable aspect of these amendments, because these changes certainly stand on their own merits. In fact it would be easy to underestimate the effect of these amendments on our older citizens. We should not forget that social security cash benefits are practically the only source of regular income for many millions of our retired citizens. About one-half of the aged social security beneficiaries have less than \$12.50 a month in continuing retirement income other than their social security benefits. So when we talk about social security benefits paid to these people we are talking about the wherewithal for food, shelter, clothing, and the other necessities of life.

I am especially pleased that the increase in benefits will be retroactive to January. Last summer this House passed a general benefit increase and the other body also provided for a general increase in benefits. But because the conference committee could not agree on matters unrelated to a benefit increase the 20 million people who live on these payments did not get improved benefits. H.R. 6675 will correct this situation. I want to heartily endorse this provision as a very responsible action.

I am pleased to have had a part in formulating this program. We took into account not only the impact of the fine benefits under this program, but also the economic effect of the social security trust funds. Our committee has assured that these reserves will not build up in the near future to the extent that they would hurt consumer demand and the Nation's economy. Our committee has also provided for some relief for the self-employed by making future increases in the contribution rates for self-employed people less than the 1½ times the employee rate as under present law.

Mr. Chairman, the speakers who have preceded me, including the extremely able chairman of the Committee on Ways and Means, the distinguished gentleman from Arkansas, have explained in detail the provisions of this legislation. I would, however, like to point out as another example of the assistance which this legislation will give to the people in the State of Illinois the changes which were made in the public assistance medical vendor provisions. The table on page 75 of the report shows that without the expenditure of a single additional cent of money the State of Illinois will, by spending the same amount it is presently spending on medical payments under public assistance, receive more than 18 million dollars over and above what it is now receiving. This obviously will be of considerable and lasting benefit to our needy citizens.

The provisions of H.R. 6675 are going to benefit the entire country, Mr. Chairman. These monthly checks go to every part of every city, to every village and hamlet, and they are a continuing source

of income coming in every month. In my opinion our committee has reported a very fine bill and it deserves your support.

I certainly would like to make the observation that while I am a somewhat new member of the Committee on Ways and Means, I have never had the pleasure before of seeing gentlemen work in a committee in such accord for the benefit of the people of this country, and I certainly would be remiss if I did not commend every individual on that committee for making the outstanding contribution that they have made, particularly Mr. BYRNE, who was most constructive in his observations on this legislation.

The CHAIRMAN. The time of the gentleman has expired.

Mr. KLUCZYNSKI. Mr. Chairman, in the 15 years I have been privileged to serve in the House of Representatives, we have had before us many measures of vital—often urgent—importance to this great Nation of ours. We have worked diligently, and I believe successfully, to meet and deal with the increasingly complex domestic and international problems that have confronted us in the 20 years since the end of World War II.

We take pride, and justly, in the legislative achievements that have contributed so much to the work toward world peace, to the struggles for independence and advancement around the world, to the magnificent—often almost incredible—advances in scientific and technical fields, and to the upward progressive march of our own culture and economy.

With all this, though, I do not believe we have enacted any legislation that reaches deeper into the hearts of our people than does the measure before us today. In one form or another we have been reaching for this goal throughout the years I have served here. I have actively supported all the efforts that bear fruit here today, and it is a very real personal satisfaction to me, as I am sure it is to all of us, that we are at last meeting our obligation to the people who have made us what we are.

Our senior citizens are the people who built this great country of ours. They came from all over the world; they worked in the fields and the factories and in the mines and the mills; theirs was the labor that constructed the foundation of our splendid standard of living, theirs the toil that educated the children who now sustain this country in its world leadership. They gave us the opportunity to become great. Now, having realized so much of that opportunity, and with so much more before us, it is our responsibility to insure that their twilight years shall be years of peace and contentment. It is to our parents and grandparents, the senior citizens of today, that we owe the tradition of determined individual independence that is the cornerstone of our national life. We would be unworthy of their untold gifts to us if we failed now to make it possible for them to maintain that independence in their remaining years.

Through the program we enact today, our senior citizens will be able to face the future without the haunting fear of crushing debt, or the humiliation of dependence upon their children, that all too often comes with the illnesses of age. And we do it, not only for the senior citizens of today, but for those of our own generation and the generations to come. And by so doing, we help to insure not only that our older people will be more secure, but that our younger people will be more free to raise new families with fewer burdens and achieve greater and greater things.

Most of what has been written and said about this legislation has been concerned, and rightly so, with the medical care it provides. I am equally pleased, however, that it also provides the long overdue increase in general social security benefits, that it extends its protection to widows, to dependent children, and to the disabled. There is probably no legislative field that affects more directly the needs of our people as individuals and reaches into the American family to sustain it.

It was not planned to happen this way, of course, but I think it is fitting that we have this legislation before us at this time. The winter is behind us and our earth renews itself once more. And in this season we again renew our dedication to humanity. We could not demonstrate that dedication more surely than we do now in this program.

Mr. ANNUNZIO. Mr. Chairman, I rise in support of H.R. 6675. I am proud to have the opportunity to take part in this historic debate. There can be no doubt in anyone's mind as to the result of our deliberation here this afternoon. At long last, Congress is about to enact a sound program for assuring America's senior citizens adequate medical care.

Proposals to provide medical care for the elderly have been under consideration for 10 long years. As time has passed, the problem has grown in scope—the need for the program has become increasingly urgent.

We all know what the miracles of modern medical science have accomplished. Infant mortality has been reduced, dozens of fatal and crippling diseases have been eliminated, the life span of the average American citizen has been extended by decades.

What we have been slow to recognize is that these very successes have created new problems in place of the old. The most advanced technology is of little value unless its benefits are available to those whose need is greatest. Extra years of life are a dubious gift unless they can be lived in dignity.

Yet, consider the circumstances which confront America's elderly. Past their peak earning years, people over 65 must live on pensions, social security payments, and whatever savings they have been lucky enough to accumulate. Generally these sources produce an income that is hardly enough to meet their daily needs.

At the same time, older people face drastically increasing medical expenses. Older people get sicker more often, have

to enter hospitals more frequently, must stay in hospitals for longer periods, and require more treatment than persons who have not borne the burdens of life for so many years. Fully 80 percent of the 17 million Americans over 65 years of age have some chronic diseases for which they desperately need medical treatment.

The problems involved in paying for this treatment out of an already meager income have been compounded in recent years by a startling increase in medical costs. The fact is that the cost of good health has been going up drastically—faster than almost any other cost factor of daily living. Over the last decade, the consumer price index has increased by some 12 percent—a reasonable increase in a growing, vibrant economy. But the cost of medical care has gone up by 36 percent and the cost of hospital care by 65 percent in the same period of time. And these are costs that retired people not only must meet out of a fixed income but out of an income that was fixed by retirement plans based on the lower earnings and the lower prices that prevailed in past years.

People living on \$2,000 or \$3,000 a year simply cannot afford \$35 a day for hospitalization. Yet that is the average cost today. Nor can they look with much hope to private health insurance plans; for the premiums, even when coverage is available, are prohibitive, to people in this income group. The inevitable result is that millions of elderly Americans face the prospect of choosing between pain and poverty and all too often they suffer both.

The program we are about to enact recognizes that such a state of affairs is intolerable. It also recognizes that the only feasible way to come to grips with the problem is through a program of health insurance financed under the social security system.

We have examined many other alternative solutions. We have given the Kerr-Mills program, which was enacted over the objections of those who foresaw that it could not meet the need, a fair trial; it has proven to be inadequate. Only 25 States have chosen to participate in Kerr-Mills and the extent and quality of coverage varies from State to State.

So now the time has come to place medical care for the elderly where it belongs—under the uniform and universal provisions of social security. This is the logical extension of the system of compulsory social insurance that was enacted 30 years ago.

Just as opponents of social security focused their criticism three decades ago on the compulsory elements of the system, so the enemies of H.R. 6675 try to convince us now that such a health insurance plan denies Americans the freedom of choice.

But clearly the American people have made their choice. They made it at the polls—most recently and most overwhelmingly last November. Perhaps no other single issue lost so many votes for the Republican Party as the issue of placing social security on a so-called voluntary basis. For the American people know that in the end this would

destroy the system, rob the aged of earned benefits, and place an intolerable strain on the welfare resources of the Nation.

We can enact this bill as it stands today, confident in the knowledge that historians of the future will mark this day as the time when we took one more giant step toward the Great Society.

Mr. Chairman, I want to take this opportunity to commend the great chairman of the Ways and Means Committee, the Honorable WILBUR MILLS, of Arkansas, for the tremendous skill he has displayed in bringing before this House a bill that is designed to serve the needs and wants of all Americans.

I also want to commend the members of the Ways and Means Committee for their support of the chairman of this great committee.

Mr. Chairman, I am proud to support this bill, H.R. 6675, and to vote for its enactment because it represents a new day, a new era in the behalf of the people of America.

Mr. HELSTOSKI. Mr. Chairman, this will long be remembered as the day upon which our senior citizens and their families were freed from the specter of financial ruin caused by major illness.

The elderly of our Nation—and indeed all citizens—owe a debt of gratitude to Representative WILBUR MILLS and his committee for their determined and tireless work. This labor, it is certain, will result in final passage of this vital legislation. The committee's perseverance, under the inspiring leadership of Mr. MILLS, and its recognition of the needs of the great majority of our senior citizens will be looked upon with gratitude and blessings across the Nation.

Voluminous testimony has proved beyond doubt the great need for old-age health insurance. Its passage will correct what must be considered one of our national shortcomings—the fact that this Nation, 30 years after establishing the social security system, still has not enacted a similar program extending health care to the elderly. It is almost unbelievable that we have let so many of our aged, and their children upon whom they depend, face financial catastrophe in times of illness during the past three decades.

Statistics tell the story, Mr. Chairman. Four out of five persons 65 or older have some type of serious illness. They spend twice as much time in hospitals as young people, so it costs them twice as much. And because these older people in most cases are no longer employed and are ineligible for employer-employee health plans, almost half of them have not a penny of health insurance.

More than 3,500 constituents of the Ninth New Jersey District previously indicated by their letters and personal calls to me their concern over this legislation. These communications, received before our proposal emerged in its present form, indicated that 67 percent were in favor of medicare. The evolution of the legislation as now proposed, with its supplementary voluntary health insurance program, has brought an even more favorable response. Since this new program was announced I have received 480 letters commenting on its value. Mr.

Chairman, 80 percent of these people urged me to support this legislation.

Furthermore, spokesmen for several senior citizens organizations have visited my district office, urging support of this bill. Their pleas carry much weight, for they know best the day-to-day threat illness imposes upon the pensioner living on a fixed income.

Mr. MILLS' committee has taken many arguments and objections under consideration and has included in its proposal recommendations made by the administration as well as those of the American Medical Association and Republican committee members.

This legislation represents a solution based on logic—no argument overshadows the commonsense of putting pennies away while you are employed in order to be able to pay big dollars out in medical costs when you are beyond working age.

Freedom from medical bankruptcy will be achieved through the basic hospital insurance programs. Further protection will be afforded at nominal cost by the optional supplementary medical program providing physicians' services. Together, these two programs will free older citizens to become participating members of society. Secure from financial worries, they can become useful volunteers in their communities. And since this hospital care will have been purchased during their working years there will be no stigma of accepting charity. They will be getting only what they have already earned.

And as a further aid to our pensioners, who find it increasingly difficult to keep up with today's rising costs of living and property taxes, the legislation includes a 7-percent increase in social security benefits.

Medical help for the aged is long overdue. I welcome the opportunity to come to the aid of our senior citizens and pledge my wholehearted support of this program.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield such time as he may require to the gentleman from Virginia [Mr. BROYHILL].

Mr. BROYHILL of Virginia. Mr. Chairman, the House membership is attempting to resolve a medical problem which is complicated, as evidenced by the bill before you of nearly 300 pages, by the committee report of some 264 pages, which includes the report of the majority and the report of the minority. To those of you who have not had the opportunity of sitting with the House Ways and Means Committee for the past nearly 3 months, let me attempt to give you my impression in summary fashion of the real problem that is before us.

First of all, no one denies that some of our senior citizens have difficulty in meeting the expense of illness. In attempting to solve the problem for them, there are three considerations which can each be treated in the alternative. They are as follows:

First. Do we attempt to provide medical care to every aged person who has difficulty in meeting the expense of illness or do we provide medical care for all aged persons?

Second. Should we make whatever

program which is decided upon a part of our social security system or is the better course to keep it entirely separate, using general revenue for financing?

Third. In setting up a program, should we best assign the administration of whatever program we decide upon to the States, which are closest to the problems, or do we use a bureau of the Federal Government?

After having listened to several hundreds of hours of testimony and reading reams of tables and statistics, this fairly junior member of the Ways and Means Committee has reached a decision in each of these three areas. It is my considered opinion that it is far more preferable for Government to provide total medical care for every person who needs it rather than to give less than total care to every person in the aged class. In reaching this decision, I see that my thinking is in accord with past decisions of the Congress in the more than 20 Federal welfare programs which are presently on the books.

These programs include low-cost housing, tuition under the Federal Defense Education Act, the four categorical public assistance programs, the many veterans programs and even the cash benefits program of the Social Security Act, to name but a few.

In the housing program we do not provide housing for all persons—of course not. We provide housing for the families with inadequate levels of income.

In the Defense Education Act we do not provide tuition for all students; rather, only those good students whose families cannot afford the cost of providing their bright child a college education.

The four categorical programs all are for those who cannot fend for themselves.

And so it goes down the list.

The second consideration, as to whether we establish a program closely associated with social security or apart from it and using general funds, I resolved in favor of avoiding any connection with social security—and I mean any. I am aware that you are being told that there is a safety factor because we have a separate trust fund and I know from examining the record that this is an illusory safety factor, because in 1956, when Congress established a separate trust fund for the disability program, it was claimed that this would safeguard any inroads on the cash benefits insurance program and the record clearly shows that within 10 years, or by 1966, this fund would have been bankrupt or will be bankrupt but for the 50 percent increase provided in the reallocation of social security tax income, which reallocation is a part of the administration's bill which you are presently considering. I know that too many people are depending upon our social security insurance system to undergird their retirement program. Many people, with the help of commercial insurance companies, have built a retirement plan using social security as a base or foundation, and I, for one, do not choose to be a party to any legislation which will endanger the solvency

and actuarial soundness of that foundation stone of retirement of millions of American people.

The third consideration which I mentioned earlier is whether Congress should in any legislation which is passed assign the job of administering the program to State governments or to a bureau of the Federal Government. I am certain that the closer we get to the people and the problems which they have, the more realistic and more efficient system will be produced. But I am not unyielding in my views and I would even forego and, in fact, have foregone this third objection which I have to the administration's measure when I signed the minority views and thereby supported the Republican alternative health plan.

But I am unyielding on the first two points. I cannot for the life of me change my thinking this late in the game as to espouse any legislation which involves the Federal Government in providing goods or services to any segment of the population which can itself make provision from its own assets. Nor can I be yielding, as I have said earlier, in any threat to the social security insurance system in the face of the many failures which are around us everywhere in the world, including the recent experiences in England, France, Italy, Belgium, and Japan—to name but a few.

Let us look briefly at the experience of some of these foreign nations which have adventured into the heady brew of government medicine. Here is what the NBC News Commentator Chet Huntley had to say on March 23, 1965, about the 23,000 general practitioners who recently made threats to quit the British National Health Service:

The row, however, began when doctors asked for a pay increase. Well, as hot as the money issue is, that isn't all of it.

The general practitioner in Britain claims that he is simply too overworked, too ill equipped, and that he is forced to live under a kind of new tyranny exercised by the patients, who now feel that health care and doctor's attention are theirs by right.

Britain has been losing doctors at the rate of almost 500 a year. The number of medical students is declining, and already below the level of 1938. Meanwhile, the population grows. * * *

Well, the program simply has not done well. So, there is genuinely a lot of dissatisfaction with the British National Health Service, but it might be of some profit to us to know and understand precisely what the complaints are, now that we are about to step gently into the area of public health care.

Amen, Chet, Amen.

Now, what about France?

U.S. News & World Report carried this item in its September 28, 1964, issue:

De Gaulle has a new problem, and he can't seem to locate the answer in the back of the book. Problem, familiar to American taxpayers, is the rising cost of social security. * * *

France's social security system, perhaps world's most extensive, is for the first time running in the red. Deficit now is a modest \$250 million. Deficit expected in 1970 is put at \$3.4 billion—almost as much as De Gaulle now spends on defense. * * *

But: Costs are going up. Medical insurance bills have more than doubled in past 5 years, now amount to about \$3 billion.

And: Social security coverage keeps expanding.

Many other nations—Italy, Belgium, Mexico, Japan, to name a few—have been plagued by protest demonstrations by physicians and allied health care personnel.

A frustrated and unhappy profession does not produce the kind of high quality care we Americans have come to expect.

A frustrated and unhappy profession does not attract the outstanding young students who seek and deserve a demanding intellectual and physical challenge and the just rewards of overcoming such challenges.

Let us give this some thought.

The experts from the Department of Health, Education, and Welfare enjoy one of the rarest privileges accorded to any department employees. These men are permitted, with a concurrence of the majority of the House Ways and Means Committee, to sit daily with the committee throughout every session. They have the right to comment on the testimony of witnesses who are called before the committee. The Department's actuary always seems to have the last word.

In the administration's bill, which is before you, at present day cost figures and with the Department's advice, the committee's majority has attempted to put into the program approximately \$12 per month for every aged person for those portions of the bill covered by social security and also \$6 a month into that portion of the bill not covered by social security, which was borrowed from the Republican proposal, for a total of approximately \$18 per month. Now, of course, figures that we use on today's market and the goods and services that these dollars buy may not be too meaningful in the future, but you must understand that the committee has provided a package for about \$180 a year per aged person when the Department of Health, Education, and Welfare itself furnishes us with the average cost of medical services for every aged person as being \$360 per year.

You may properly ask, what has the committee done? Have they provided half of the average proper health services for each person, or have they provided a good medical benefits program which is only 50 percent fully financed? And that is a good question, because for the really needy person with a major illness, it does not avail us to provide him with 50-percent recovery or 50 percent of his needed health services.

Let me nail down this \$360 health expenditure per year on the part of the aged. HEW last estimated the average cost for the person over 65 at the beginning of 1962 as being \$315 annually. Since that time, they have been applying a 5 percent per year compounded increase in cost. This, then, produces an average cost of approximately \$360.

In the executive hearings, which, as you know, began in January and did not end until about a week ago, testimony was taken from many witnesses. The Health Insurance Association of America brought several actuaries before our committee and left us with a warning that HEW's estimate of level cost—0.96 percent of payroll—missed its mark by some 0.42 percent of payroll.

The insurance industry estimate was 1.38 percent of payroll. Those estimates will be found on page 437 of volume I of the printed executive hearings.

But the estimates of the Social Security Administration, which take into account a very small factor for overuse simply because the program becomes free, misses the mark completely when you compare the anticipated utilization of health facilities under a government program with actual use, the closest example to us in point of geography being the 20-year experience that the Province of Saskatchewan has had, wherein hospitalization utilization rose almost 300 percent in the first 13 years of that program's experience. A repetition of that experience would certainly play havoc with the soundness of the social security system.

But, then, we are told to disregard the actual experiences of other countries because this country will be different. I am afraid we are going to have to disregard a lot of experience and good advice if the majority of the members of this body vote to adopt the administration's bill. We are going to have to disregard as well the advice of the two groups most expert in the provision and payment of medical care; that is, the physicians of this country and the health insurance industry of this country.

As one of the original 35 sponsors of the eldercare bill, I believe it to be far superior to the so-called medicare approach in H.R. 6675.

I would also emphasize that the medical profession has thrown its support behind the eldercare bill, and that Congress has been deluged by a flood of letters supporting the eldercare concept.

My preference for the eldercare approach over the medicare plan is based on the fact that the eldercare proposal avoids compulsion, minimizes Federal regimentation and allows a broad range of benefits under State-administered programs.

Under eldercare, the extend of aid to the recipient would be based on his need for Government assistance, thus making the best possible use of tax dollars.

I have maintained that the quality of medical care and medical science would deteriorate under a Government-operated health care system. While it is true that the health care benefits under H.R. 6675 are provided principally for the elderly, it is unrealistic to believe that the program will not expand.

It is difficult to realize that the modern history of attempts to provide health care through a federalized system began 30 years ago when there were some recommendations for a health insurance title in the original social security bill.

In 1939, Senator Robert F. Wagner introduced a bill which included a national health program, one of Federal grants increasing over a 10-year period.

A few years later, the Wagner-Murray-Dingell bill proposed a compulsory national health service system for most citizens.

Public appeal for the Wagner-Murray-Dingell type of legislation diminished in the 1950's and compulsory programs for

the general population failed to become a major legislative issue.

Then, in 1957, Congressman Aime Forand introduced a bill which would have provided broad hospital, surgical and nursing home benefits under the social security system for all those eligible for the old-age and survivors benefits.

The 1957 Forand bill didn't get anywhere and neither did a similar proposal in the following 86th Congress.

In 1960, the Kerr-Mills bill establishing a Federal-State program to help the needy and near-needy elderly obtain health care was passed into law.

But this did not have the effect of slowing down the efforts of the proponents of social security financing.

A series of King-Anderson bills—watered down versions of the Forand bill—were introduced in succeeding Congresses.

The avowed aim—to open the door to social security medicine.

Let us give this some thought.

Now, here we are today, pondering a three-layer cake, providing the biggest and costliest welfare program since social security itself began.

It is going to cost us \$6 billion a year in 1967.

And it would raise the maximum social security payroll tax from the present \$174 to \$252 in 1967—a \$78 jump.

Mr. Chairman, the debate on this measure is not to be construed as involving the question of who is for the old folks; it is not concerned with any questions of compassion for those who have need of Government assistance. We are all for helping the aged and we would all like to do even more than is proposed to be done here. But as a businessman I can tell you that a significant part of this debate involves the question of how best to finance whatever it is that we do in the way of providing benefits.

For a number of reasons I am opposed to financing any health service-type benefits by means of a payroll tax within the framework of social security. I have already expressed concern that obligating the social security system for service-type benefits may impair the program's ability to meet its obligations to pay cash benefits. My concern is not allayed by the subterfuge of a separate tax and a separate trust fund when we have involved the same program, the same taxpayers, the same employers, the same recipients, and the same Government agency. The sameness is there in the eyes of the people even though we go through the useless gesture of legislatively prescribing different labels.

The payroll tax that the majority proposes as a means of financing its compulsory medicare program constitutes the most regressive type of taxation. In this case it will strike hardest at those least able to afford it. Service-type benefits under the system will not be wage related. Benefits will be paid with respect to many of our aged who have no need for Government subsidy and these benefits will be paid for by increased taxes—for the most part on persons who are raising families and seeking to educate their children.

Mr. Chairman, as a part of my supplementary individual views that begin on page 258 of the committee report, I included at the end of those views six tables which my esteemed colleague, the gentleman from Missouri [Mr. CURTIS], and I requested the able staff of the Joint Committee on Internal Revenue Taxation to prepare. I would like to direct your attention to these tables which are set forth on pages 262 through 264 of the report and comment briefly on them. I will use rounded figures for ease of reference.

As I proceed, bear in mind that these tax rates and these tax burdens apply to individuals and employers alike. In combination, they tend to reduce take-home pay, increase the cost of goods and services, reduce return on investments, and discourage the creation of employment opportunities—hardly the professed objectives of the Great Society.

In table 1 we see that in the year 1965 a rate of 3½ percent is applied to a taxable wage base of \$4,800 to produce a tax on the employee of \$174, which is matched by a similar tax on his employer to total \$348. Next year this combined tax will increase by \$100 if the employee earns as much as \$5,600. And these totals are only for the cash benefit part of the program and assume no future liberalizations in the program; they do not include the so-called basic health insurance program. Beginning on January 1, 1973, the combined employer-employee tax for only cash benefits will be \$635.

Table 2 relates to the self-employed and shows similar data as I have described with respect to employed individuals in table 1.

Table 3 sets forth the tax rates and amounts applicable to individuals and employers for the basic program of health benefits. These are over and above the rates and amounts delineated in tables 1 and 2. As you can see, even under the proposed bill these tax increases continue going up for 22 years or until 1987, and if I am correct in my concern about this program being underfinanced, this is just the beginning.

Table 4 particularly merits the attention of those of us who are working to sustain and expand the economic growth of our free enterprise society. This table in terms of billions of dollars indicates the total tax burden on individuals and employers—for the years 1965 through 1972 under present law and the pending bill. In 1965 total social security taxes will amount to \$17.2 billion and next year, if H.R. 6675 is enacted, the total of such taxes will amount to \$21.9 billion—or an increase of \$4.7 billion. In 7 years the tax burden will nearly double to an aggregate amount in excess of \$33 billion. Now, all of this increase is not solely attributable to H.R. 6675, but I submit to you that in their effect on the economy it makes no difference whether the tax increases occur as a result of existing law or because of the bill now before us. A tax increase is a tax increase by any other name.

Dwelling a bit further on table 4, I would like to call your attention to two recent comments of concern over taxation that bear on the significance of

the data presented in that table. The first of these is contained in the majority views of the report by the Joint Economic Committee on the President's Economic Report. On page 9 of Joint Economic Committee report, the following expression appears:

The committee is concerned, however, over the possible repercussions of the rise in social security contribution rates scheduled for January 1, 1966, and urges that the Federal Government be prepared to take decisive action if the forward progress of the economy is checked.

The second comment to which I will refer is a remark made by the recently retired Secretary of the Treasury, the Honorable Douglas Dillon, before a group meeting under the auspices of the American Bankers Association a few weeks ago in Washington, D.C. At that time, Mr. Dillon asserted that taxes imposed on our low-income citizens are too high and need to be reduced. Mr. Chairman, I agree with the observation by the Joint Economic Committee majority and I agree with Mr. Dillon. The tax impact of this bill is in conflict with the majority of the Joint Economic Committee and with the concern expressed by Mr. Dillon.

Table 5 on page 264 of the committee report shows that the combined tax rate under the committee's bill ultimately reaches 11.2 percent applicable to a taxable wage base of \$6,600. It is to be remembered that this rate applies before deductions and exemptions. It is in effect closely akin to a gross income tax.

Table 6 reveals the total tax to be paid with respect to an employee and we learn that it reaches an ultimate level of \$740. I remind you that this ultimate tax rate and this ultimate tax burden are only for the social security program as it will be modified by the bill now before us. If we want to liberalize benefits in the future or add to the health care program, we will have to add taxes on top of the taxes we propose to add under H.R. 6675.

Mr. Chairman, it is easy to vote for greater benefits but, as we do, we must remember that the benefits we propose must be offset by the taxes we impose. The Government can give only if the Government taketh first.

Although there are many provisions in H.R. 6675 which I believe to be meritorious, the dangers in the compulsory health care features of the bill are so serious that I must oppose the bill as reported by the committee.

I have repeatedly stated that one of the major problems of the elderly is to see that social security cash benefits keep up in some measure with the rising cost of living.

Accordingly, I am in favor of the 7-percent increase in social security pensions.

At the same time, I wish to point out that the hospital and nursing home care benefits, supported by social security tax dollars, will mean that there will be less funds available to provide cash increases in the future. We may even preclude forever the opportunity to raise cash benefits.

I would also point out that part of the frosting on the committee's three-layer

cake would include physicians under the social security system.

This is plainly another slap at a profession which has served us so nobly and so well.

The other professions, such as law and dentistry, were given an option to elect social security coverage.

Physicians, who have steadfastly voted as a profession against social security coverage, should be accorded the same privilege. Physicians in my district tell me that most doctors do not retire at age 65 and, therefore, do not need and do not want social security coverage. Furthermore, a substantial portion of the doctors are in private practice and would be subject to the self-employment tax, which is equivalent to 150 percent of the employee social security tax.

Moreover, it is ironic that H.R. 6675 would allow the Amish and members of other religious sects which oppose social security to withdraw from this program at their option.

Gentlemen, we have been given an awesome responsibility.

Will we be known as the body which admitted its hasty actions and came to honest grips with the problem?

Or will we be known as the House which opened the door to a new concept of welfarism which slowly but inexorably eroded the vitality of a great nation?

Certainly we can go along with what we mistakenly believe to be the majority view.

But will our consciences go with us?

I submit that the people have given us a mandate—not on specific legislation—but to use our minds for the best interest of our Nation.

In the past several months, I have detected a certain disdain among my colleagues regarding the views of the medical profession on this important matter.

Flushed with the November bounty, they have scarcely heeded the warnings of physicians regarding the inherent danger of social security medicine.

The medical profession—especially in the past 29 years—has brought us into a virtual “golden age of medicine.” Indeed, there is general agreement that “there has been more medical progress in the past two decades than in the previous two centuries.”

American physicians—educated in a tradition of freedom and excellence—have been the architects of this golden age.

Are we now—as in that childhood story—about to kill the goose that lays the golden egg?

Let us give this some thought.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield such time as he may require to the gentleman from New York [Mr. LINDSAY].

(Mr. LINDSAY asked and was given permission to revise and extend his remarks.)

Mr. LINDSAY. Mr. Chairman, Congressmen who introduce bills on subjects they consider exceptionally important often find themselves in a dilemma when the time comes to vote—not on their bill, but on a bill directed toward the same goal.

Rarely does the bill meet all of the Congressman's expectations when measured against his own legislation. The question is whether the right course is to accept a somewhat different approach or to hold fast to one's own ideals of how the legislation should be constituted.

Many of us must make that decision today.

For 30 years, this country has been at odds over how it should help its elderly citizens protect themselves against the high cost of illness.

As early as 1935, responsible groups were asking the President and Congress to develop a national health insurance plan which would be workable and fair.

Mounting costs of hospital and nursing care, coupled with a steady increase in our elderly population, have made health protection for the aged a major national problem.

The need is plain as the figures and the cases increasingly demonstrate. More and more, we hear of an entire family's savings wiped away by the high cost of hospital or nursing home care. Science and the medical profession have made wonderful advances in making it possible for people to live longer.

As a result this country's population over age 65 is increasing at the rate of 1,000 a day. This year, it passes the 18 million mark. By 1980, the census tells us, our aged will number 24,458,000—an increase of more than a third in the next 15 years.

Almost one-half of the over-65 population in the United States must live on income of less than \$2,500 a year. Worse, nearly half of the aged who live alone have incomes of less than \$1,000 a year. One-half have liquid assets of less than \$1,000. About 40 percent have less than \$5,000 total assets, including homes.

Added to the problem of scarce funds is the fact that one-half of our over-65 citizens have no health insurance. Many more have grossly inadequate coverage.

Yet four out of five have a chronic ailment. With this high tendency to illness, our over-65 citizens need three times as much hospital care as younger people. And the aged are the primary users of nursing homes and chronic disease hospitals. In New York City alone, there are nearly 11,000 nursing homes.

And the cost of hospitalization is rising rapidly. Even in 1961, the latest complete figures we have, the average cost of each day in the hospital was \$35.

The total cost of health care for persons over 65 is estimated at more than \$5 billion a year. Nearly half of this goes into hospital and nursing home care, including custodial and mental hospital care.

The facts are before us: The growing number of elderly citizens, the financial problems many of them face, the high cost of and therefore the lack of insurance, the tendency of the aged to chronic ailments, and the increased cost of hospital care.

The basic question we face as a nation is how best to help our aged meet this problem. I suggest that a broad-scale health insurance program for all of our aged, financed through a payroll tax, is the best kind of help we can give.

The payroll tax—the same financial

source that the social security program uses—can be applied to most of the working force of our Nation; has a wide base; is easily collected, and does not fluctuate as much as the income tax. Further, we could not load a broad program of hospital care for the aged onto the progressive income tax or the corporate income tax. Higher rates in those areas would, in my opinion, have a serious impact on our incentive to increase profits and income through growth.

Some years ago, then consistent with these principles, I introduced proposed legislation that would provide a broad program of hospital care financed by a measured pay-as-you-go system—the broad-based payroll tax. I believe the payroll tax is fair—it is shared 50-50 by employers and employees, and is paid by the self-employed during their working years. It creates an insurance fund financed by the broadest possible tax base. Some would argue that a hospital plan should be financed totally by general revenues. It is argued that this would remove the involuntary feature of the payroll, or social security tax. But I know nothing voluntary about the income taxes that we pay to make up the U.S. Government's general revenues.

My bill differed from H.R. 6675 chiefly in its option feature. Under this option in the Lindsay-Tupper bill a beneficiary could convert the value of his interest in the fund at age 65 into cash to be applied to the premiums of a qualified private health insurance program. H.R. 6675, on the other hand, provides a different option. It adds a voluntary insurance program for nonhospitalization medical costs. I cannot say that the difference is so great as to make me vote against the provision in H.R. 6675. Both methods will encourage the growth and development of private health insurance and voluntary prepayment plans, particularly in the field of catastrophic illness. This I believe is desirable.

I note with satisfaction that H.R. 6675 establishes a separate health—or hospital—insurance trust fund. I believe that my original proposal was the first to have drafted in it this separation.

Thus, plan A of the bill before us is very similar in content and scope to the Lindsay-Tupper bill, as it is known, and I think represents a step forward. The option feature of the Lindsay-Tupper bill was designed to create flexibility and to encourage the private sector. I believe this feature has been substantially satisfied by plan B in the bill before us, the voluntary, contributory insurance plan.

One may ask, why not a total bill made up of plan B, as has been proposed in somewhat different form? The answer is that it is too costly and too much to load on general revenues. Eventually, I am sure, it would require an increase in the income tax. Hospitalization, as I pointed out, is by far the highest cost factor of the medical problems of people over 65. They also happen to be the “mechanical” costs; that is to say, they have nothing whatever to do with the practice of medicine as such. I am firmly convinced, then, that the sound way to finance such a program is through the broad-based payroll tax.

Now then, Mr. Chairman, let me talk more specifically about H.R. 6675. Under the rule of procedure under which we are operating, no amendments are permitted. So we must talk about the bill as it stands. Features of the Lindsay-Tupper bill not already adopted are no longer possible of inclusion.

First, it need hardly be said that this bill represents one of the most significant pieces of legislation to come before Congress since I have been a Member of the House.

The bill is an effort to insure that no American who is 65 or older will go without basic hospital care during a time of illness because of need. It further offers a voluntary insurance program which would—among other benefits—pay the fees of physicians and surgeons. Persons 65 or over may participate in the plan or not, as they wish. The premiums are reasonable. One of the current problems, of course, is the unreasonableness of premiums for persons over 65, if they are insurable at all.

The basic plan, which is the hospitalization part, would be financed by a separate payroll tax, as is the existing social security system. It is known as plan A. The proceeds of the tax, which would be carried equally by employers and employees, would be paid into a hospital insurance trust fund in the Treasury Department. The program is to be administered by the Department of Health, Education, and Welfare.

Plan A, the basic hospitalization plan, does not exclude those persons who are not receiving social security benefits. They are covered automatically if they presently are age 65 or more, or if they will be 65 before 1968.

Plan A is to go into effect July 1, 1966, except for extended case services, which are to be allowable July 1, 1967. The supplemental voluntary insurance plan for physicians' services and other medical expenses also provides that benefits be paid starting July 1, 1966.

The benefit schedule under the basic Plan A, is as follows:

The services for which payment would be made include—

First. Inpatient hospital services for up to 60 days in each spell of illness with the patient paying a \$40 deductible amount; hospital services would include all those ordinarily furnished by a hospital for its inpatients; however, payment would not be made for private duty nursing or for the hospital services of physicians except services provided by interns or residents in training under approved teaching programs;

Second. Posthospital extended care—in a facility having an arrangement with a hospital for the timely transfer of patients and for furnishing medical information about patients—after the patient is transferred from a hospital—after at least a 3-day stay—for up to 20 days in each spell of illness; 2 individual days will be added to the 20 days for each day that the person's hospital stay was less than 60 days—up to a maximum of 80 additional days—the over-

all maximum for posthospital extended care would then be 100 days in each spell of illness;

Third. Outpatient hospital diagnostic services with the patient paying a \$20 deductible amount for each diagnostic study—that is, for diagnostic services furnished to him by the same hospital during a 20-day period; if, within 20 days after receiving such services, the individual is hospitalized as an inpatient in the same hospital, the deductible he paid for outpatient diagnostic services—up to \$20—would be credited against the inpatient hospital deductible—\$40; and

Fourth. Posthospital home health services for up to 100 visits, after discharge from a hospital—after at least a 3-day stay—or extended care facility and before the beginning of a new spell of illness. Such a person must be in the care of a physician and under a plan established within 14 days of discharge by a physician calling for such services. These services would include intermittent nursing care, therapy, and the part-time services of a home health aid. The patient must be homebound, except that when equipment is used the individual could be taken to a hospital or extended care facility to receive some of these covered home health services in order to get advantage of the necessary equipment.

No service would be covered as post-hospital extended care or as outpatient diagnostic or posthospital home health services if it is of a kind that could not be covered if it were furnished to a patient in a hospital.

A spell of illness would be considered to begin when the individual enters a hospital or extended care facility and to end when he has not been an inpatient of a hospital or extended care facility for 60 consecutive days.

The deductible amounts for inpatient hospital and outpatient hospital diagnostic services would be increased if necessary to keep pace with increases in hospital costs, but no such increase would be made before 1969. For reasons of administrative simplicity, increases in the hospital deductible will be made only when a \$5 change is called for and the outpatient deductible will change in \$2.50 steps.

Basis of reimbursement: Payment of bills under the basic plan would be made to the providers of service on the basis of the "reasonable cost" incurred in providing care for beneficiaries.

The basic plan would be financed as follows:

Separate payroll taxes to finance the basic plan, paid by employers, employees, and self-employed persons, would be earmarked in a separate hospital insurance trust fund established in the Treasury. The amount of earnings (wage base) subject to the new payroll taxes would be the same as for purposes of financing social security cash benefits. The same contribution rate would apply equally to employers, employees, and self-employed persons and would be as follows:

	Percent
1966-----	0.35
1967-72-----	.50
1973-75-----	.55
1976-79-----	.60
1980-86-----	.70
1987 and thereafter-----	.80

The taxable earnings base for the health insurance tax would be \$5,600 a year for 1966 through 1970 and would thereafter be increased to \$6,600 a year.

The schedule of contribution rates is based on estimates of cost which assume that the earnings base will not be increased above \$6,600. If Congress, in later years, should increase the base above \$6,600, the tax rates established can be reduced under these assumptions.

The cost of providing basic hospital and related benefits to people who are not social security or railroad retirement beneficiaries would be met from general revenues. This is expected to cost about \$200 million per year at the outset of the program.

The supplemental voluntary program, sometimes referred to as plan B, would be financed through the payments of premiums by those individuals over 65 who desire the insurance. The initial premium would be \$3 per month, deducted, when applicable, from social security or railroad retirement benefits. The Government would match the premium with \$3 paid from general fund revenues. The minimum increase in cash social security benefits for retired workers, as provided elsewhere in H.R. 6675, is \$4 per month, or \$6 per month for a man and wife receiving benefits based on the same earnings record. Thus the benefit increases would fully cover the amount of monthly premiums. The premiums would be deducted from social security or railroad retirement benefits.

The procedure for enrolling in the supplemental plan is as follows:

Persons aged 65 before January 1, 1966, will have an opportunity to enroll in an enrollment period which begins on the first day of the second month which begins after enactment and ends March 30, 1966.

Persons attaining age 65 subsequent to December 31, 1965, will have enrollment periods of 7 months beginning 3 months before attaining 65.

In the future general enrollment periods will be from October to December 31, in each odd year. The first such period will be October 1 to December 31, 1967.

No person may enroll more than 3 years after close of first enrollment period in which he could have enrolled.

There will be only one chance to re-enroll for persons who are in the plan but drop out and that must be made within 3 years of termination of previous enrollment.

Coverage may be terminated first, by the individual filing notice during enrollment period, or second, by the Government, for nonpayment of premiums.

A State would be able to buy in for its public assistance recipients who are receiving cash assistance.

Benefits to be provided in the supplemental insurance plan are as follows:

The supplementary plan would cover physicians' services, home health services, hospital services in psychiatric institutions, and numerous other medical and health services in and out of medical institutions.

There would be an annual deductible of \$50. Then the plan would cover 80 percent of the patient's bill—above the deductible—of the following services:

First. Physicians' and surgical services, whether furnished in a hospital, clinic, office, or in the home;

Second. Hospital care for 60 days in a spell of illness in a mental hospital—180-day lifetime maximum;

Third. Home health services (without regard to hospitalization) for up to 100 visits during each calendar year;

Fourth. Additional medical and health services, whether provided in or out of a medical institution, including the following: Diagnostic X-ray and laboratory tests, electrocardiograms, basal metabolism readings, electroencephalograms, and other diagnostic tests; X-ray, radium, and radioactive isotope therapy; ambulance services—under limited conditions; and surgical dressings and splints, casts, and other devices for reduction of fractures and dislocations; rental of durable medical equipment such as iron lungs, oxygen tents, hospital beds, and wheelchairs used in the patient's home; prosthetic devices—other than dental—which replace all or part of an internal body organ; braces and artificial legs, arms, eyes, and so forth.

There would be a special limitation on outside-the-hospital treatment of mental, psychoneurotic, and personality disorders. Payment for such treatment during any calendar year would be limited, in effect, to \$250 or 50 percent of the expenses, whichever is smaller.

I wish to point out two largely unpublicized aspects of the bill which I think will prove to be of considerable concern to older people.

The first is that persons 65 and older will no longer be able to deduct all of their medical expenses on their Federal income tax returns. H.R. 6675 would amend the Internal Revenue Code so that these persons, like all persons under 65 in present law, may deduct only those medical expenses exceeding 3 percent of their adjusted gross incomes, and only those expenses for drugs and medicines which exceed 1 percent of their adjusted gross incomes.

Second, the bill would amend the code so that all taxpayers—irrespective of age—will no longer be allowed to deduct all of their expenses for health insurance. The bill would limit the deduction for medical insurance premiums to one-half the amount paid during the tax year, up to a maximum of \$250.

I don't think that either of these provisions should have been included in the bill. They place the Congress in the position of bestowing a health insurance program with the one hand, while with the other repossessing part of what it earlier had given.

Since, as I have said, we are prevented by the rules from offering an amend-

ment, I can only express the hope that if and when the bill goes into conference with the Senate the section will be eliminated. I agree with the general principle that the jerry-built scheme of deductions and exemptions in the Internal Revenue Code should be reformed. I submit, however, that this is no way to attain that end.

H.R. 6675 is not solely concerned with health insurance; it makes dramatic changes in other sections of the social security program.

First, the bill provides a 7-percent across-the-board increase in benefits to social security recipients, retroactive from January 1, 1965. The minimum increase for retired workers at age 65 will be \$4 per month. These increases will affect some 20 million beneficiaries.

Monthly benefits for workers who retire at 65 or older would be increased to a new minimum of \$44 and to a maximum of \$135.90. The present figures are \$40 and \$127.

To finance these increases, the social security taxes paid by employers and employees will be increased in steps to 4.8 percent for the year 1973 and years thereafter. The taxable earnings base would be increased from \$4,800 to \$6,600 between January 1, 1966 and 1971.

The bill also provides that social security recipients may earn more without suffering reductions in their benefits. The bill provides that the States may double the present \$10 exemption for a recipient's monthly earnings. Also, the States may exempt one-half of the next \$60 earned. The present exemption is one-half of \$40. These provisions could go into effect January 1, 1966.

While I shall not attempt to list all the effects of what is an extremely complex and comprehensive piece of legislation, I should mention that cash tips received by an employee are to be reported for purposes of social security payroll tax deductions and later, social security benefits. The bill provides for employer withholding of such taxes on tips employees report. This coverage would commence next January 1.

In conclusion, I have sedulously compared my health insurance bill with the legislation before us. I find that H.R. 6675 will accomplish much that my bill was intended to achieve. It incorporates two of the fundamental procedures set forth in my bill: Financing of hospitalization insurance through the payroll tax—a sound and responsible method of financing such a program and the establishment of a basic hospital plan for which the need is immediate and great. I believe the bill should be enacted and I intend to vote for it.

Mr. KEOGH. Mr. Chairman, I yield 10 minutes to the gentleman from Georgia [Mr. LANDRUM].

Mr. LANDRUM. Mr. Chairman, I believe that no one in the House of Representatives—and I am sure no member of the Committee on Ways and Means—wishes to do anything which would take away the opportunity of the people over 65 years of age to have their medical needs taken care of, when required, after they are in retirement.

In the study I was privileged to par-

ticipate in as a new member of the Ways and Means Committee, I would have to say that every member of that committee studied diligently the question of solving this quite complex problem, always keeping in mind not only the desire to solve it but the very great need to do the job without having any degree of Federal interference in the administration of our hospitals or any invasion into the practice of medicine by the Federal Government.

Certainly, I believe that all of us have striven to avoid the genesis of state medicine.

The chief bone of contention then comes not on whether to do what we are trying to do—that is, to solve the problem of medical needs of the aged—but how to do it.

My distinguished, learned, and able friend from Wisconsin [Mr. BYRNES] has suggested that we do this by a device which he has labeled a completely voluntary program but which would be subsidized to a great extent, about two-thirds, from the general revenues of the Treasury. In addition his plan would put a very heavy burden on the participants after they passed through their best earning years requiring a contribution from the retired people on an average of about \$6.50 a month according to Mr. BYRNES.

The gentleman said yesterday in the debate, in which he participated in an able and eloquent way—I quote from page 6966—

But may I point this out, Mr. Chairman? My objection to the committee bill is not on the basis of the cost. My objection is to the means used to finance the benefits; namely, the payroll tax.

It is with that feature I wish to deal very briefly.

Let us see exactly what H.R. 6675 does with the general funds. It takes \$275 million per year from the general funds to blanket in, so to speak, those 2 million uninsured people for hospital benefits under the basic hospital program.

H.R. 6675 also requires about \$600 million per year to support the voluntary plan for those who would come under the program and take the supplementary benefits.

Mr. BYRNES of Wisconsin. Mr. Chairman, will the gentleman yield?

Mr. LANDRUM. I yield to the gentleman from Wisconsin.

Mr. BYRNES of Wisconsin. At that point I believe we should have an understanding.

As to the general funds which are used to finance part of the hospitalization costs—and this is directed toward the costs of those people who today are not eligible for old-age and survivors insurance cash benefits—can the gentleman tell me the rationale for making the distinction of financing their benefits of the general fund but of financing the benefits of other people over 65 who are retired today out of the payroll tax.

I think it would be interesting if we could have an explanation as to why that distinction is made and these people are put into two different categories.

Mr. LANDRUM. I think that distinction was made yesterday in the colloquy

between the gentleman from Wisconsin and the gentleman from Arkansas [Mr. Mills] but I will try to address myself to that briefly before I close my remarks, if time permits.

Now, this makes a total of \$875 million from the general fund for the first year's operation for the hospital insurance and supplementary health insurance benefit programs of H.R. 6675. Now, for H.R. 7057, Mr. BYRNES' substitute, \$2.86 billion would be taken the first year from the general fund on the same assumptions that H.R. 6675 takes \$875 million.

Now let us look just a little bit at the philosophy of this question which has bothered people all over the country just as it has bothered Members of the Congress and as it has bothered me over the last several years.

Our principal aim, as I have said, has been to resolve this problem without going down the road to socialized medicine. We want to resolve it without having any invasion into the practice of medicine by the Federal Government. We do not want the Federal Government in the operation of hospitals. Now, I ask you, Which is the swifter more certain path to a complete and total socialized program? Is it financing this program out of general revenues or financing it with a prepaid program and limiting the general fund contribution to the very minimum required to support the voluntary program in H.R. 6675? There is only one way to get money out of the general fund, and that is through the legislative branch of the Government exercising its authority to appropriate. The legislative Members of the Government appropriate money based on what the people of the country require and need. When we say we want to avoid socialized medicine and when we say that we want to avoid deficit financing, how can we support a motion to recommit which furnishes the asphalt to pave the road further into deficit financing; to pave the road into a socialized medical structure? We are not, under H.R. 6675, saying to any hospital who can come in and who must be kept out. We are not saying to any person what doctor he must use or what doctor he must not use. All we are saying is that we want a program available when our earning years are over so that we will not be a drain on the general revenues and so that we will not year after year have to increase this initial \$2.86 billion that the motion to recommit calls for. That motion calling for \$2.86 billion this year can be expected to increase and perhaps to double within the next decade, for as our people over 65 increase in numbers and the chances for them to achieve the capacity to meet their medical needs on their own resources decreases, then greater and greater demands will be made on the general revenues and greater and greater pressures will be brought to bear on the Members of the legislative branch of the Government to appropriate to meet the needs. When you do that you will, as I have said, pave the road to socialized medicine.

The day will come when the great men and women of the medical profession today will hail H.R. 6675 as the device

that saved their profession from the socialization they rightly fear. All reasonable men can fully appreciate the apprehension and concern of the men and women of the medical profession for the preservation of the high ethical standards the profession enjoys and the close and intimate, confidential relationship that exists between the doctor and his patient. We do nothing in H.R. 6675 to invade or disturb those standards and relationships.

Mr. Chairman, now I want to make one additional point that concerns me greatly about this motion to recommit. I heard yesterday, as I have heard today and as I have heard over the few weeks that I have been privileged to be a member of this great Committee, statements of great admiration and respect for the Chief Actuary of the Social Security Administration, Mr. Robert Myers. Upon having a question propounded to him about H.R. 7057, he provided a memorandum dated April 6 about the actuarial balance of the OASDI system under H.R. 7057, the proposed substitute in the motion to recommit. I would like to read this statement from Mr. Myers:

H.R. 7057, introduced by Mr. BYRNES on April 1, would establish a program of voluntary, comprehensive health insurance for all persons aged 65 and over—

And get this now—

and would also modify the OASDI system in the same manner as H.R. 6675. However—

That word "However" covers lots of things.

However, H.R. 7057 would significantly affect the cost of the OASDI system because the premium for the voluntary health insurance would be paid from the OASI trust fund with respect to insured workers aged 65 and over who are not receiving cash benefits because of the retirement test. In other words, H.R. 7057 includes a further liberalization of the retirement test over that provided by H.R. 6675. The cost of this change is estimated at 0.07 percent of taxable payroll and, accordingly, affects the actuarial balance of the program.

Under H.R. 6675, there is a small lack of actuarial balance of the OASDI system amounting to .08 percent of taxable payroll, which is less than the established limit of 0.10 percent of taxable payroll as the maximum actuarial imbalance that can be present for the system to be said to be sufficiently close to actuarial balance. Under H.R. 7057 the lack of actuarial balance would be increased 0.15 percent of taxable payroll or beyond the acceptable limit. On this basis, it would seem that H.R. 7057 should carry additional financing, such as having an ultimate combined employer-employee contribution rate of 9.7 percent beginning in 1973.

Now, then, we have under the committee bill only 9.6 percent for 1973.

Mr. BYRNES of Wisconsin. Mr. Chairman, will the gentleman yield?

Mr. LANDRUM. Not at this point, please. I shall in a minute.

Mr. BYRNES of Wisconsin. I thought I would yield the gentleman additional time.

Mr. LANDRUM. I shall yield in just a moment, please.

Mr. BYRNES of Wisconsin. I do not care whether you do or not.

Mr. LANDRUM. What I am trying to say at this point is this. Whether you

are for or against the committee bill should not influence your attitude about this motion to recommit. You cannot be for this motion to recommit and expect to keep your OASDI system in appropriate actuarial balance.

The Chief Actuary of the Social Security Administration tells us—and I heard the gentleman from Wisconsin [Mr. BYRNES] yesterday express his deep admiration and respect for Mr. Myers, and I agree with him, and I heard the chairman express the same admiration and respect for Mr. Myers—that we cannot accept H.R. 7057 as a substitute if we want to keep the OASDI system in appropriate actuarial balance. That is, regardless of how you feel about the committee bill. So I say if you are concerned, as I have heard many say they are concerned about the actuarial soundness of this social security system, and I am not concerned—I think it is sound, I think it has been proven to be—but if you are as I have heard many say they are, concerned about it then you cannot support the motion to recommit, with instructions. I say that without regard to how you may feel toward the passage of the committee bill and its enactment into law.

Now, I yield to the gentleman from Wisconsin.

Mr. BYRNES of Wisconsin. I will take my own time. Thank you.

Mr. LANDRUM. Thank you, sir.

Now, Mr. Chairman, let me reiterate: I believe we will take a step today as significant as the step that was taken 30 years ago when the social security system was enacted into law. I heard some of our political leaders of that day say—and as a matter of fact I joined in some of that thinking—that the social security system as it was enacted would take us into socialism. I have heard the same people 30 years later say it was that system, it has been that social security system, that has prevented us from going into socialism. It has saved us from becoming a complete welfare state.

Mr. Chairman, I say today that by taking the step we are about to take, while disagreed to by many at the present, that in the days to come the people, the doctors, all Americans everywhere, will sing the praises of those who had the courage and the foresight to stand against the substitute and enact a law that will preserve the high ethics and lofty standards established by the great men and women who make up the medical profession of this country.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield myself 2 minutes.

Mr. Chairman, I asked the gentleman to yield in order to save time, possibly, to report to him and to the other Members of the House that the motion to recommit will revise that section to which he was alluding and to which he referred that does have an effect on the old-age survivors disability insurance fund. I think the method used in bill H.R. 7057 is a good method.

As the gentleman pointed out, it is a relaxation of the work clause. However, the basic bill provides some relaxation in the work clause which I think is a salutary move. This would have been a

little further move in the relaxation of the work clause. I would point out, however, that the cost of the proposal to the social security system would have been seven one-hundredths of a percent of payroll.

The social security trust fund today is out of balance by eight one-hundredths of 1 percent after this bill is enacted, as reported by the committee. Another seven one-hundredths percent would not put it in the danger area. We have been advised by the actuary of the Social Security Administration that we need not become exercised as long as we kept the imbalance, as far as their estimates are concerned, within a tolerance of twenty-five one-hundredths of 1 percent out of balance. So even if this is in the bill it would not be of any great moment, I would suggest to the gentleman from Georgia. But because of the fact that there is some concern that maybe this does make an exception as far as the use of social security funds are concerned, the decision has been made that bill H.R. 7057 would be amended so what we will use in the case of the adjustment necessary for these people who are over 65 but still working is the same method of adjustment as is contained in the committee bill with reference to the adjustments that have to be made to these same people under the voluntary portion of the committee plan. It will be identical in that respect in the motion to recommit.

The CHAIRMAN. The time of the gentleman from Wisconsin has expired.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield 10 minutes to the gentleman from Kentucky [Mr. CARTER].

(Mr. CARTER asked and was given permission to revise and extend his remarks.)

Mr. CARTER. Mr. Chairman, I speak to you concerning H.R. 6675. The die is cast; the Rubicon is almost crossed.

Since I hail from Appalachia, where it seems now they always have the blues, I thought today I might recount a short history of medical practice in one of these depressed and desolate areas—the medical history of the county of Monroe—referred to by Kentucky's leading newspaper as the scrubs hills county of Monroe.

After World War II two relatively young physicians entered the practice of medicine in this hill county. The nearest hospital was 26 miles away. So these physicians, country doctors if you will, were forced to do much surgery in their offices and in homes. A jeep was a necessary instrument of that practice. So far as I know, no one was turned away from the physician's doors. Calls were made into the hills and on two occasions patient's husbands lost their ways in taking the physicians to their homes.

In 1952 this impoverished people, by public conscription and a bond issue and with Hill-Burton funds, started a hospital which was completed in 1953. Since that time no patient has been turned away because of lack of funds or for any other reason. After the hospital was built patients from Monroe and adjacent

counties came in increasing numbers. Instead of two active physicians, there are now eight in this county.

The first bond issue was paid off in 10 years and a 24-bed addition was completed in 1964 with a second bond issue and a second Hill-Burton grant.

Two small group practices now flourish in this county whose average individual income is approximately \$1,400. They are housed in modern clinics with excellent X-ray and laboratory facilities. And both were constructed without Federal aid.

The nonprofit hospital has accumulated operating capital of \$15,000 to \$20,000—part of which was used in a recent modernization of the portion constructed in 1953.

It is acknowledged that the Kerr-Mills program has been extremely helpful.

Gentlemen, this is an example of what the free and unfettered practice of medicine can do, even in impoverished Appalachia. How do I know this? It happens, gentlemen, that at the age of 54 I am the oldest physician in this county.

We now are embarking on a new adventure in medical practice, one in which the rich will enjoy the same free medical care we have always given the poor. I would ask if the expenditure of these vast sums of money is necessary to help the rich instead of the poor who really need the help. I would ask if medical practice will remain free of the fetters of Federal control. I would ask if our young people desire to increase their already heavy burden of taxation.

As one of the last country doctors, I am not here to criticize medical care for the aged, but rather to support it.

I ask my colleagues, who along with me have given this proposal serious study, to vote to recommit H.R. 6675, a bill which will within a few years cruelly overburden the social security system and the young workers with growing families, who will be forced to pay higher and higher social security taxes. By providing aid on the basis of need, the Byrnes proposal would assure that both Federal and State dollars were providing the greatest amount of care where they are the most needed.

Under the Byrnes proposal, the Government would have no reason to intervene in the practice of medicine. Protected by his insurance policy, the citizen's freedom of choice of doctor, hospital, or nursing home would remain the same as it has always been.

Returned questionnaires which I have just sent out from my office indicate that an overwhelming majority of the people of my district prefer this approach over medicare. Let us not be inveigled into blindly supporting the medicare program under social security when, with a longer view, we can see a better plan to help our needy, elderly citizens meet their doctor and hospital bills.

I humbly ask your consideration of recommitment of this bill and your consideration of the Byrnes proposal, which was formulated with the assistance of physicians who are most experienced in the needs of our ill and infirm.

For myself, I will continue in such time allotted to me for the practice of medicine and surgery with the motto learned many years ago of "service before self." And as good citizens, come what may, we will always comply with the law of the land.

Mr. KEOGH. Mr. Chairman, I yield 10 minutes to the gentleman from Pennsylvania [Mr. RHODES].

Mr. RHODES of Pennsylvania. Mr. Chairman, every Member of this House, as Dr. HALL, our distinguished colleague suggested, will make their decision on this legislation based on what is believed best for our country and its people.

Everyone is interested in quality medical service and there is no intent to harm in any way the medical profession. In fact some of the Nation's most dedicated and able physicians see the necessity for this legislation.

Mr. Chairman, enactment of the legislation now under consideration will be a historic decision. It has been hailed as the biggest social security bill in history and the most important and far-reaching step forward since the start of the program during the New Deal administration of Franklin D. Roosevelt.

I wish to commend the gentleman from Arkansas, the Honorable WILBUR D. MILLS, the distinguished chairman of our House Ways and Means Committee, for his leadership in bringing this comprehensive social security bill to the House floor for a decision. No one in the Nation is better informed on this question than our distinguished chairman. Under his able leadership, it was possible to bring forth a bill which I believe has widespread public support and approval. It is a privilege to serve with him as a member of his committee. I know I speak for all committee members in commending him for his fairness, as well as for his devoted and dedicated leadership.

This legislation will mean much in meeting the needs of our aged and retired citizens. This advance in social security is part of President Johnson's effort for a Great Society. It is part of the war against poverty. It is a recognition of the responsibility of government to bring adequate medical and hospital care within the reach of all of our aged citizens, without, as in many cases, exhausting all their assets and life savings. It gives the elderly the opportunity to benefit from the marvels and advances made in medical science.

The enactment of this bill will result in a better balance in our economy. It will add to the economic strength and well-being of our Nation. Improved consumer purchasing power through increased social security benefits will create additional job opportunities for many workers who are being displaced by automation, and for young folks who leave school each year to enter the labor market.

Congressional approval of this legislation will be a recognition, by this administration, of the overwhelming mandate which the voters of the Nation gave in electing as President and Vice President, Lyndon B. Johnson and HUBERT H. HUMPHREY, and a Democratic Congress.

It will be the redemption of a platform pledge by those of us who made this a campaign issue last year.

There will be those who will oppose this bill, Mr. Chairman, just as there were bitter opponents who fought against social security when it was first enacted, and against every advance that has since been made. Just as predictions of national bankruptcy, regimentation and the loss of freedom were made in bygone years, so will voices of fear and reaction be raised again, by enemies of social and economic progress. We hear repeated requests for delay, for further study and more time for debate, but everyone here knows we would hear these worn-out arguments even if the decision was postponed a week, or even another year. But there will be others, who will see the need of further improvements to make the social security program more adequate in meeting the needs and problems of the aged, the disabled and the less fortunate among us. Despite the progress that this bill represents, the new minimum cash benefit will be but \$66 a month for a retired couple. This is far from enough to meet basic needs today.

There are other inadequacies which require amendments for further improvements. In this age of automation, employment opportunities will continue to decline for persons 45 years of age and over. All of which points to the need for a reduction in the social security retirement age.

A number of bills have been introduced to lower the age requirements for full retirement benefits to 60 years. This proposal, I believe, deserves first priority in making additional improvements in the program.

There is also the need for liberalization of the disability provision, which now requires 40 quarters of social security coverage to be eligible for benefits. When crippling disability strikes a young worker, it frequently leads to years of economic distress for him and his family. Bills which have been introduced to lower the requirements for disability benefits deserve prompt consideration and favorable action.

The social security program should also be amended, as the distinguished gentleman from Florida [Mr. PEPPER] said yesterday—to provide benefits to families stricken with catastrophic illnesses. It is social injustice to ignore the plight of families, who have a tremendous expense and a heavy financial burden, in addition to the suffering and hardships associated with such illnesses.

I am confident, Mr. Chairman, that eventually these changes will come. But they are not possible unless we give more serious thought and attention to financing additional improvements.

For this reason, I believe the Federal Government should contribute to the social security fund, matching payments by employees and employers. A one-third Federal contribution would increase social security fund reserves by 50 percent. This would strengthen the fund and make possible badly needed improvements without an additional un-

just tax burden on low-income wage earners. It would finance a needed increase in benefits, a reduction of retirement age to 60, disability benefits after 1 year of coverage, and other needed improvements.

Such an expansion in the social security program would further provide job opportunities for young people, as more older folks retire. The economy would be strengthened through the increase in purchasing power that would follow.

Expansion of social security is essential in the building of the Great Society and for a better and more fair distribution of the national income, wealth, and prosperity. The advance of automation, the shut-down of obsolete industrial plants and out-dated government installations require prompt and favorable action on this type of legislation, as well as on other administration proposals for a full employment economy.

In most of the advanced democracies, particularly in Western Europe, the Federal Government contributes to the financing of the social security and medical assistance programs.

Even conservative critics, of the legislation now before us, make a good case for Federal contributions when they point to the heavy burden of social security taxes on wage earners.

The extreme right Manion Forum publication, in its most recent issue, makes a good case for my proposal for Federal contributions. In their criticism of the present social security tax, Dean Manion said, and I quote:

The person who has been paying social security taxes for years gets no more service and attention under medicare than the person who has never paid any social security taxes at all, and this may be a very wealthy person whose income is derived entirely from rentals, interest, and dividends.

The Pennsylvania Medical Society was critical of financing improvements in the present bill with increased payroll taxes whereby they say, and correctly so, that "a \$5,600-a-year worker would have to pay as much medicare tax as the \$75,000-a-year executive."

Unintentionally these conservative forces make a good case to place some of the social security costs on high incomes and on interest and dividends which escape this tax, as Dean Manion admits.

It seems to me that there should be a ceiling established on payroll taxes. When the individual tax reaches 6 percent it is time to consider additional means of support for the social security fund.

One of the Nation's best-known and most popular statesmen has recently suggested that consideration be given to Federal contributions.

I speak of the distinguished junior Senator from New York, the brother of our late President, John F. Kennedy, who has contributed so much to the progress of the legislation we expect to approve today. The gentleman from New York made the suggestion at the 14th annual meeting of the National Council on the Aging at the Shoreham Hotel in Washington, D.C., on March 2, 1965, only a few weeks ago.

With permission of the House already granted, I include the Senator's address with my remarks:

ADDRESS BY SENATOR ROBERT F. KENNEDY AT THE OLLIE A. RANDALL AWARD AND DINNER 14TH ANNUAL MEETING, THE NATIONAL COUNCIL ON THE AGING, MARCH 2, 1965, SHOREHAM HOTEL, WASHINGTON, D.C.

Mr. Shelley, Dr. Dosco, President Meyer, Mrs. Mathiasen, and distinguished guests, I am pleased to be with you at this year's meeting of the National Council on the Aging. Since its founding in 1950, the Council has played a leading role in the effort to help older people lead more comfortable, more complete, more dignified lives. Your work has ranged over the whole spectrum of problems of the elderly—housing and employment, retraining and retirement, medical care and medical indigency. For all, you have contributed substantially to the search for constructive solutions. I therefore feel especially honored that you have asked me to address you.

And it is especially appropriate that we meet today. This year, as we mark the 30th anniversary of the passage of the Social Security Act, we will enact the medicare bill—a charter of freedom from undue fear of illness and injury—into which President Kennedy put so much of his energies and efforts.

I need not dwell here on the significance of medicare. The costs of hospital and related care for the elderly have risen sharply as time has passed, and with each rise in cost, an increasing number of older Americans are unable to afford adequate medical care. We all know that medicare does not solve all the medical-cost problems of the aged. But it is a significant first step—and it is an imperative step.

I would like to talk this evening about what comes next—about a thorough evaluation of the basic structure of the social security system. Social security was designed to give our elderly a hope for decent life in retirement, a new chance to live out their days in dignity and peace instead of poverty and despair. When Franklin Roosevelt transmitted the original social security bill to the Congress, he pointed out that the Nation had a plain duty to establish a sound means of averting the dreadful consequence of economic insecurity. The bill, he said, was directed "toward a greater future economic security of the American people." I think it is time we took a careful look to see whether social security is now fulfilling that purpose—and what we must do to insure that it does afford our older citizens the measure of protection which they need and deserve in their last years.

I do not wish to minimize the importance of other, related problems. We face equally great challenges in finding ways to utilize the skills and abilities, the experience and knowledge of our older citizens; in providing adequate housing for the aged; and in expanding research into the causes and prevention of the illnesses and diseases associated with the aging process. But my major subject this evening is the economic security—or lack of it—which the social security system gives our retired citizens.

The basic fact is that, in the midst of unprecedented prosperity our older citizens live in poverty. The Bureau of Labor Statistics estimates that it costs about \$3,000 for a retired couple to live at a modest but adequate level in a big city, and \$2,500 in a smaller community. Yet in 1962, half of the 5-400,000 aged couples in this country had incomes of less than \$2,875, and 30 percent had incomes less than \$2,000. The modest but adequate level for retired individuals is \$1,800, and two-thirds of the 8,700,000 people in this category had less than this amount. Half had less than \$1,130.

These shocking and shameful income figures are closely related to the level of social security benefits. For more than a third of its individual beneficiaries, and nearly 20 percent of couples receiving benefits, social security is the sole source of income. But in 1964, the benefits paid to retired individuals averaged \$74 a month—just \$888 a year. Benefits for aged couples averaged \$130 monthly—\$1,560 annually. Those millions who depend on social security for their entire support live in poverty.

We have, to paraphrase President Kennedy, continued to add to the years of life; but we have not yet met our responsibility to add new life to those years. Social security may provide a floor of protection to our elderly. But it is a floor without a carpet; and the nails come through.

We have always relied on individual savings and pensions to supplement social security. But for too many, there are no adequate supplements. This is by definition the case for the millions of elderly people who live in poverty. These are the people whose lives have always been a struggle, the people who were never able to save significant sums, the people who never worked for a firm which had a private pension plan. For these millions the sole hope upon retirement is an adequate pension under social security.

We have a long way to go.

The figures I have cited demonstrate that increases of 100 percent or more are needed for the lowest-income groups if we are to provide them with adequate benefits. We must recognize that this is going to be a costly proposition. How, then, are we going to foot the bill?

Within the present scheme, there are two ways of getting greater contributions—raise the payroll-tax contribution rates, and increase the maximum earnings base subject to contributions and creditable for benefits.

There does not seem to be too much room left for doing the former. Many are reluctant to raise the rate much over 10 percent for the employer and employee combined, and increases already projected will bring us to around that level. Increasing the maximum earnings base will be of some help. If, for example, the base were increased to \$7,200, as this year's Advisory Council report recommended, individuals who earn \$400 a month on the average would get benefits of \$144 monthly instead of \$127. Couples with those earnings would get \$226 a month in benefits instead of the present \$190.50. Some have suggested that the maximum earnings base could realistically be raised as high as \$9,000 or \$9,600, but even that would not be enough to provide the level of benefits essential to a life of modest comfort and dignity.

To provide these benefits, I think we must begin to consider a limited use of general revenue financing for the system.

Economically, a limited turn to general revenues makes a good deal of sense. The payroll tax is highly regressive. Its major justification has been that a payroll tax is basically contributory. In the main, the worker gets out during the years of retirement what he put in during the working years.

Yet, to a significant extent, this is no longer the case. Considerations of social justice have modified the strict relation between benefits and earnings. We have provided benefits to poorer and more irregularly employed workers; to widows and orphans; to those disabled by injury and illness. And we have always paid benefits to workers who were too old when the program began to make a full contribution for the benefits they are receiving.

In all these ways, the social security system has responded to genuine social needs. Through it, we are now providing benefits to deserving people who properly were not asked to pay for them. But we are doing so out of payroll contributions of others—and

the payroll tax is highly regressive. That is why I say a limited turn to general revenues would make a good deal of sense.

Financing the extra benefits which I have mentioned out of the progressive income tax instead of the regressive payroll tax would greatly ease the burden on middle and lower income wage earners. It would allow a return to use of the payroll tax as a basically contributory device; and it would free a substantial sum to be used for the benefit of those who had contributed it.

Nor is there anything revolutionary in suggesting that we must be considering a limited use of general revenues in the social security system. The first presidentially appointed Council on Economic Security, whose report preceded the enactment of the Social Security Act, said that Government contributions to the system would eventually be needed, adding prophetically that, "It will not be necessary to have actual Government contribution until after the system has been in operation for 30 years."

The 1938 Advisory Council made the same recommendation, giving as its reason that "the Nation as a whole, independent of the beneficiaries of the system, will derive a benefit from the old-age security program. * * * The Council also said, pertinently, that "with the broadening of the scope of the protection afforded, governmental participation in meeting the costs of the program is all the more justified. * * * The 1938 Council stated the principle to be one of distributing the eventual cost of the old-age insurance system by means of approximately equal contributions by employers, employees, and the Government."

The social security board itself in 1939 called it "sound public policy to pay part of the eventual cost of the benefits proposed out of taxes other than payroll taxes, preferably taxes such as income and inheritance taxes levied according to ability to pay." The board added that "the wider the coverage, the more extensive this contribution from other tax sources might properly be."

In 1946 the House Ways and Means Committee's technical staff recommended a continuing Federal subsidy up to "a third of the year's total of benefit and expense payments." The 1948 Advisory Council called a Government contribution a recognition of the interest of the Nation as a whole in the welfare of the aged and of widows and children. I might just add that these advisory councils were not composed of wild-eyed radicals. Both the 1938 and 1948 groups included such highly respected names as Edward R. Stettinius, Jr., and Marion B. Folsom.

There is, therefore, sound historical basis for undertaking now to consider utilizing a contribution from general revenues to help provide adequate benefits for the lowest-income participants in the social security system and to help finance the payments of benefits to other beneficiaries who were never able to contribute in full for what they are now receiving. And there is sound economic basis as well. We will, over the next few years, have more than sufficient general revenues for a constructive contribution to social security without any increase in taxes. The present growth rate of the economy is $3\frac{1}{2}$ percent annually. Some say it will be even greater, but even at $3\frac{1}{2}$ percent the present tax rates will generate an annual revenue increase of \$6 billion. By 1970, the income tax will be yielding the Federal Government an estimated \$30 billion more every year than it is today. I think we can certainly afford to contribute some of this to social security. By doing so we will considerably ease the pressure on State and local welfare costs which are now skyrocketing. The dollars we put into raising social security benefits for the lowest income retirees to an adequate level will directly lighten the load on public assistance—a load, I might add, which is often financed by regressive

State and local sales and property taxes. If we are going to deal with the problem, I think it makes a great deal of sense to use the income tax to do it.

I would like now to turn to some specific items, some particular things which we ought to do to improve the overall adequacy of the social security system.

First, specific action is needed to improve the position of the widow under social security. The average widow's payment is now only \$67 a month—\$804 a year. Widows should receive benefits of the same magnitude as their deceased husband's primary benefit. Widows deserve disability coverage, too, as do disabled wives of retired or disabled workers. The lack of coverage in this area represents a significant threat to economic security.

Second, I think it is imperative that we modify the retirement test, which causes reductions in benefits for workers earning over \$1,200. As the law now stands, unless a man can earn quite a substantial sum, he will begin actually losing money as he earns over \$1,700; at that point his tax-free social security dollar will be replaced by taxable earned dollars on a 1-for-1 basis. It is important to the policies underlying social security that there be an earnings test, but I think that at present it goes into operation at an inequitably low level, and should be raised significantly.

Third, disability benefits are, in my judgment, in need of certain reforms. At present the law requires that a disability be expected to be of indefinite duration, in effect permanent. President Kennedy recommended in 1961 that the requirement of permanence be removed, leaving only the requirement that the disability be total. Coupled with a provision for payments immediately upon determination that a total disability exists, this would provide the economic security needed. Further, the requirement of inability to engage in any substantial gainful activity is unduly hard on older workers who, though unable to perform their usual work could theoretically, though not practically, obtain other employment. I would liberalize the definition of disability for workers over age 55 so they need not show inability to engage in any and all substantial gainful activity, but only in the activity in which they were previously engaged.

These things we must do—and we will do them. But we must above all not rest content with the achievements of yesterday or today. We must continue our concern, and our attention for these problems—never allowing the passage of time and the change of circumstances to outmode our solutions. We must learn to pay better and more regular attention to the need for increased benefits. Even during the past 4 years, during which we did a good job in holding the line against rises in the cost of living, consumer prices rose about 5 percent. If we are not going to provide any automatic formula for increase—as we have done under the civil service retirement system and the military service pension system—we must be prepared to legislate regularly to raise benefits, not only to keep pace with the cost of living, but to allow our elderly to share in the rapid gains in productivity which we have been experiencing. Our inaction does not leave things as they are. It allows them to deteriorate.

But the basic choice is a plain one. Social security, for many of our senior citizens, will be only a way of keeping partial reliance on public assistance from turning into total reliance—unless we do whatever is necessary to provide an adequate income for all retired Americans. We must insure that "the best is yet to be, the last of life, for which the first was made." It is up to us.

Another proposal for financing needed improvements, Mr. Chairman, comes

from an editorial in the Senior Citizens Sentinel, Los Angeles, Calif. The Sentinel is the voice of the National League of Senior Citizens headed by Mr. George McLain, one of the Nation's foremost leaders of Senior Citizens. The Sentinel editorial follows:

BRING IT UP TO DATE

For 25 years millions of Americans have been receiving monthly social security checks. Yet, there are still more people who find this reality hard to accept, who appear to believe the system is only a transient, radical idea destined to be abolished just as soon as we can teach people the simple virtues of thrift and foresight.

Certainly anyone in touch with social reality knows that social security is here to stay and that its promise of security for every American family is also realistic in our technologically developed economy. This was the intent of the original legislation. And the only thing holding back this promise is the failure of our lawmakers to keep the system up to date, to provide new financing for rising living standards of retired people, and to make up the losses caused by inflation.

There are those who have deliberately tried to make the payroll tax deduction as burdensome as possible in order to disillusion the average worker with the whole idea of social security, playing on his fears of bigger and bigger tax bites to finance the benefits. But it is not necessary to continue taxing the small wage earner.

Instead of raising the percentage on a low tax base, which is now a maximum of \$4,800, the tax base itself should be raised. Tax base is the taxable portion of a worker's income. When social security first started in 1935 it was \$3,000 and in 1965 it is still only \$4,800. It has not kept pace with rising wages in the inflationary spiral. A base of \$14,500 now would be comparable to \$3,000 in 1935, covering 95 percent of total covered earnings.

The tax base should be raised now to at least \$7,500, without changing the percentage of payroll deduction. It still wouldn't catch up with inflation. But it would provide additional revenue with which Congress could raise benefits by as much as 50 percent. The report of the Advisory Council on Social Security, recently released, confirms the soundness and necessity of adjusting the taxable base upward to a realistic level so that the burden will be shared by higher income groups. As President Johnson said, in connection with other legislation, Congress must not "delay, hesitate, or compromise our purpose."

Another interesting editorial was published in the Washington Post of February 25, 1965. It pertains to the sharp rise in social security payroll taxes and the financing of social security improvements. The Post editorial follows:

FINANCING SOCIAL SECURITY

There is now a broad consensus in Congress on social security legislation. Retirement benefits are to be substantially increased this year, and, barring an unlikely political upset, Congress will establish a modest program of hospital insurance. A great deal of attention has been given to expanding social security benefits, but the important question of how they are to be financed has been neglected. And therein lies a danger. By adhering to the maxim that benefits must be paid out of current payroll taxes, the economy may be dealt a severe deflationary blow.

Under the administration's King-Anderson bill increases in regular social security retirement benefits would be made retroactive to January 1, and assuming its passage by July 1, net benefits payments, measured at annual rates, would increase by \$2.6 bil-

lion in the second half of this year. This fiscal stimulus, coming at a time when the growth of private expenditures may be tapering off, is most welcome. But unless the King-Anderson bill is carefully amended, the economy may be rudely jolted by the \$5 billion increase in social security taxes that will become effective on January 1, 1966.

If this sharp rise in payroll taxes is not cushioned, the economy may again be plagued by a fiscal drag. By suddenly boosting social security taxes, the full employment surplus—the budgetary surplus that would obtain if the economy were operating with only 4 percent unemployment—will be increased. And with a higher full-employment surplus, greater diversions of taxes from the income stream will dampen economic activity.

The fiscal threat inherent in the planned tax hikes may be easily averted without weakening the social security trust funds. Congress should defer any increase in payroll taxes until the end of 1966, and beginning in 1967, the tax should be raised in a series of small steps. Shortfalls in meeting social security claims can be paid out of general tax revenues. But, given the growth of social security receipts at current tax rates, these contributions would not be large. And as the scheduled increases in tax rates were effected, the need for Treasury contributions to the trust funds would be rapidly diminished.

The need for cushioning the impact of a boost in social security payroll taxes is urgent. But Congress should also consider other deficiencies of the present social security system. By limiting the increase in the payroll tax base to \$5,600, the King-Anderson bill consigns social security a minor role in providing adequate retirement incomes. The Advisory Council on Social Security proposes a \$7,200 income base, a level which would permit a lowering of payroll tax rates and opportunity to increase the benefits conferred upon those in the lowest income groups.

Steps should also be taken to lift the limitation on earnings by retired persons. If social security benefits are an earned right, paid for by the insured during their working years, no means test should be interposed.

Mr. Chairman, these editorials and remarks by the junior Senator from New York deserve most serious consideration by the Congress.

In conclusion, Mr. Chairman, let me say that the new social security bill which is now on its way to final enactment, was approved by the Ways and Means Committee after many months and even years of study and debate. Volumes of testimony have been printed and distributed expressing all points of view presented by every interested group.

During the last few weeks, before the decision was made, the committee invited testimony again from interested parties. Dr. Donovan F. Ward, president of the American Medical Association, appeared before our committee with two aids. Among other expert witnesses who testified in recent weeks were representatives of hospitals, nurses, nursing homes, group health organizations, doctors favoring medicare, senior citizens, and other groups. Few pieces of legislation ever had such lengthy hearings. The issue has been widely debated and discussed in Congress and throughout the Nation.

Proponents of "eldercare" influenced support for the voluntary health insurance feature of the medical care pro-

gram. The AMA charge that medicare was inadequate because it was confined largely to hospital and related care brought support for a comprehensive bill. The claim that eldercare would provide broader coverage than King-Anderson helped to influence the decision to include additional benefits through subsidized voluntary health insurance.

A difference of opinion among physicians was quite evident. Many of them supported medicare and requested the inclusion of physicians under the social security program.

Mr. Chairman, H.R. 6675, the Social Security Amendments of 1965 had my full support in committee. I will vote for the legislation today and I hope and believe it will pass by an overwhelming vote.

Finally, Mr. Chairman, I want to pay a personal tribute to some of the pioneers whose efforts have helped pave the way for enactment of this legislation.

The Nation's senior citizens owe a debt of gratitude to these pioneers. Among them is our distinguished colleague from California, the Honorable CECIL R. KING, a cosponsor of the King-Anderson bill. He has been a target for reactionary attacks because of the leadership he gave in fighting for this legislation. To mention a few others, I also include our former colleague, Aime Forand, who back in 1957 began the campaign by introducing the Forand medicare bill. The deceased father of our distinguished colleague, JOHN DINGELL, Jr., who has presided as Chairman in the Committee of the Whole during debate on this historic legislation, was another courageous leader in this fight. A former chairman of the House Education and Labor Committee, John, senior, was one of the original sponsors of legislation such as we expect to pass in this House today.

Much credit, too, belongs to our beloved late President John F. Kennedy, one of our most brilliant Chief Executives. His efforts for this legislation has been a substantial contribution to the cause of social justice and human progress and the success that seems evident when the House decision is made today.

Mr. BYRNE of Pennsylvania. Mr. Chairman, this is a day to remember. I know that our citizens over 65, who have been praying for inexpensive health insurance for so many years, will see the introduction of this bill, the Social Security Act of 1965, as a sign that the future holds new hope, new freedom from the constant fear of catastrophic illness. A wise man once said, "It is not the end of joy that makes old age so sad, but the end of hope." Often it has been illness which has caused the end of hope for our senior citizens. Their financial resources painfully accumulated over many years have disappeared and they face a growing apprehension that the future will only bring larger medical bills and no way to pay them.

The Social Security Act of 1965, which I am proud to support, will establish a basic hospital insurance plan to provide protection against the costs of hospital, skilled nursing home care, home health visits, and outpatient diagnostic services for individuals 65 or older. Benefits

would be financed through a separate payroll tax and separate trust fund. Those aged individuals who are not currently social security or railroad retirement beneficiaries will be covered through payments made from general revenue. It is estimated that a total of 19 million citizens over 65 will be helped by this basic health insurance plan.

Basic health insurance is supplemented by a voluntary plan which provides benefits to pay for physicians' and other medical and health services. This plan is financed through monthly premiums of \$3 by individuals, matched equally by Federal Government revenue contributions. Probably more than 80 percent of the elderly would participate in this supplemental plan: the payments of \$3 a month will be more than covered by the 7-percent across-the-board increase in social security benefits which is also provided in the bill under discussion. Certainly these two plans, which complement each other beautifully, will give the elderly the financial security they so desperately need. They will be able to plan better ways to spend their small incomes, when they are not hampered by the fear of illness. Too often today they must use money which should go for necessities to pay health insurance premiums designed for younger folk who are still working and can afford to pay the cost of adequate insurance coverage. We must enact this legislation now: hearings have been held, and never has a measure received such detailed and careful consideration as have the health insurance provisions of the Social Security Act of 1965.

The bill also reforms many aspects of existing welfare legislation, and improves the general structure of the social security system by increasing benefits, continuing benefits up to age 22 for children in school, providing reduced benefits for widows at age 60, liberalizing the retirement test and extending coverage to more of our working population.

Not only the aged, but all of us will be helped by this measure. Our social security system will be brought up to date and made a part of our prosperous America which has not forgotten its debt to senior citizens. The bill also expresses our concern for the problems of those who are less fortunate, and recognizes that the Kerr-Mills program should be extended to other needy groups besides the aged. This bill is an illustration of the American way of solving social problems: thoughtfully, with slow deliberation, but with final action which will result in immediate and long-range improvements.

Mr. Chairman, I urge all my colleagues to vote against the recommittal and to support the bill.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield such time as he may require to the gentleman from Indiana [Mr. BRAY].

(Mr. BRAY asked and was given permission to revise and extend his remarks.)

Mr. BRAY. Mr. Chairman, it is with great reluctance that I must oppose this legislation, which admittedly is aimed at relieving some of the financial burdens

of our older citizens. Through the years I have consistently worked to improve the social security system and to broaden its coverage and benefits. I always have been guided by the desire to make the program one of maximum usefulness so long as its basic fiscal soundness is not impaired. As for the increase in social security benefits, this increase also is included in the substitute bill. I voted for an increase in social security last year as did most Members of this body but the realization of this increase was blocked by the administration.

We could with proper legislation make great progress in bettering the medical and hospital service for our elder citizens but the bill before us today unfortunately strikes at the future solvency of the social security system. It also would threaten to place our medical profession in a quagmire of governmental bureaucratic control and inefficiency and defeat the very purpose that we are attempting to attain.

It also is unfortunate that the committee did not propose a voluntary system such as that embodied in the substitute bill which will be offered. It is regrettable that the committee bill does not involve a contributory feature for those over 65, for this means that the total burden of this program will be born by taxpayers under 65. While I believe in giving assistance where it is needed I think it is totally unrealistic to make these benefits completely available to all persons regardless of income. The substitute offers a deductible feature for persons with incomes in excess of \$5,000 per year.

The substitute bill offers greater benefits and includes most of the principles of the so-called eldercare. The substitute also includes coverage of catastrophic illness, at a lesser cost.

Mr. Chairman, I am sorry that the Committee on Ways and Means did not see fit to have full public hearings this year on this very important legislation.

I regret the fact that we will not have an opportunity to vote on individual features of this legislation but will merely be able to vote for or against it after the substitute is accepted or rejected.

In other words, I am far from satisfied with the form in which this question is presented to us for it leaves me no choice but to vote against the bill unless the substitute bill prevails.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield to the gentleman from Illinois [Mr. COLLIER], a member of the committee, 10 minutes.

(Mr. COLLIER asked and was given permission to revise and extend his remarks.)

Mr. COLLIER. Mr. Chairman, few bills that have reached the floor of this House have undergone greater legislative surgery or subsequent transformation than the bill before us today. In fact the original measure which we recommended by the administration was totally inadequate to meet the very needs which its proponents declared were so demanding of attention. In some areas the present bill does not even remove the arguments for the type of hospital insurance program which requires the extension of the Kerr-Mills concept.

Let there be no understanding that the Kerr-Mills program which was the target of constant attack by the proponents of the King-Anderson bill will in any manner be eliminated. Rather it will be expanded and will undoubtedly embrace wider participation than in any of the previous years since its adoption. I should make it clear that I am not in opposition to this phase of the bill but merely make this observation as necessary to the legislative history of it.

The legislation with which we are dealing has been substantially improved but could stand a great deal more improvement. It leaves much to be desired, particularly because it further burdens the social security system through increased payroll tax which I believe is neither necessary nor wise.

I shall not, however, indulge in any discussion on the philosophy of compulsory participation nor the alternate proposals. I would leave it to others who have and will explore all of the facets of this during the many hours of debate.

First let me state as I did on the opening day of consideration of this bill before the House Ways and Means Committee that I believe that title III of the bill should have been a separate and distinct item of legislation. In fact, it could have been passed weeks ago because this is the section which deals with the increase in old-age, survivors, and disability benefits and certain other changes in the existing law which were substantially those we passed by an overwhelming majority in the 88th Congress.

The fact of the matter is that it should have been law so that the elder citizens would already have been receiving an increase in benefits had the other body not insisted on medicare in conference a year ago and thus temporarily scuttled the entire bill.

I say that this should be separate legislation because the medicare provisions introduce a whole new concept into our social security structure, and I agree with Representative TOM CURTIS in stating that this portion should have been handled in public hearings. It is my understanding that the other body would not hear to separating the two distinctly different portions of the bill; undoubtedly because the sweeteners in title III were presumed to provide pressures for Members to vote for the whole package regardless of the fact that they might well have been wholeheartedly for the provisions of title III and not so enthusiastic about the face-lifted sections of the other titles.

For years social security has been a bargain at the price tag it carried for millions of retired citizens. But it certainly will not be a bargain for those who will be entering the labor market tomorrow or in the years ahead. In fact, I think that many workers today will be somewhat disenchanted as the whole story of the social security payroll tax is unfolded. If you look briefly at the social security system, you get some idea of what I mean in dollars and cents. I trust that as a supporter of the principle of social security, I will not be charged with tearing up a social security card in the next election.

Here are a few basic facts and figures which are, I believe, indeed revealing. In 1939 an employee earning \$550 a month paid \$30 per year into the social security trust fund and his employer paid a like sum. At that time the maximum monthly benefit was \$58 and the survivor family benefit \$85. By 1950 the same employee paid \$45 a year and his employer paid \$45, and the maximum single benefit was \$80 and the maximum family survivors benefit \$150.

This year the same employee paid \$174, making the combined annual contribution \$348, with single maximum benefits at \$127 and family survivor benefits at \$254. Now bear in mind that I am taking the maximum benefits in each instance.

But by 1973, an employee with the same monthly earnings will pay \$353.10, so that the combined payment will be \$706.20, and the benefits \$167 on the individual maximum and \$368 on the survivors family benefits.

This means that we have seen an increase of more than 480 percent in the amount the worker is paying from the inception of the program to the present, while his maximum benefits have increased only 119 percent. Now here is a really significant figure: As the bill before us is written, the worker's payment into the fund will show an increase from its inception of over 1,000 percent, with his retirement benefits by 1973 increasing 189 percent.

Now, of course, those arguing the case for expansion of social security will point to the many other provisional benefits which have been added to the program, including disability benefits and other broadening programs applying to orphan children, increased widow's benefits, and so forth. This poses a formidable argument in fact but not in figures.

However, the perpetual disparity in respect to new entrants between the value of tax and the value of benefits constantly arises. This is because increased payroll taxes must be sufficient not only to pay future benefits for new entrants but also to provide income which is the equivalent of interest on a nonexistent reserve fund.

Whether you agree or disagree with the need to do this, the fact remains that social security, as I stated before, was indeed a bargain for the pricetag it carried for many years, but I don't think it is a bargain for those entering the labor market right now.

Perhaps the best way to emphasize this point is to take the example of a young man who is entering the labor market next January first at the age of 21 years. Let us assume that he were to deposit each year the contribution that he will be paying as a payroll tax in any financial institution with an interest rate of $4\frac{1}{4}$ percent per annum.

Do you realize that at the age of 65 he would have \$42,000? Now add there-to another \$42,000, which is the matching sum his employer or employers would pay into the trust fund over the duration of his pre-retirement years, and you come up with a figure of \$84,139.

If both he and his wife live to be 77 years of age and draw the maximum social security benefits for a married couple for each year from the date of his retirement, he stands to draw in total retirement benefits \$6,000 less than his own interest-compounded contribution and more than \$48,000 less than the interest-compounded, combined contribution of he and his employer.

If you would like to figure out what the self-employed person under the same conditions would get, you will find a much greater disparity.

You might respond by saying, "Look at the protection he has under this program all these years," but I submit that every protection provided under the social security program could be purchased privately and leave this young man with a very substantial balance at the age of 65, which he of course could leave in a savings account to draw interest while using only the funds he needed to live comfortably in his retirement years. I submit that these figures have been based upon no further changes in the social security law beyond those which are before us today; no further increase in benefits; no further liberalization and no further increase in payroll taxes. But then you and I know that it has become almost standard procedure to increase social security benefits from time to time out of need through increased cost of living, as well as a smattering of political expediency or motivation.

I cite these figures and examples to stress the fact that unless there is reasonable discretion used in burdening the social security program, particularly when needs can be met without doing so, that we place in jeopardy the goose that laid the golden egg, or, better yet, reach the point where the system is one of diminishing returns.

Certainly we have an obligation to improve the program for those already in retirement and those soon to reach retirement, but it seems to me that we also have some responsibility to the generations yet to come, millions of whom may be paying more in the payroll tax under social security than they pay in income taxes, even though they will, of course, in many cases be paying an income tax upon the social security payroll tax withheld.

Separate fund or no separate fund, the manner in which the social security program is being expanded in every direction is going to reestablish the age-old fact that you cannot get 3 pounds of rice out of a 2-pound bag; and you are likely to have many future workers urging Members of Congress not to do anything more for them in this area because they just will not be able to afford it.

Mr. MILLS. Mr. Chairman, I yield 10 minutes to the distinguished gentleman from Ohio [Mr. VANIK].

Mr. VANIK. Mr. Chairman, first of all, I want to express my appreciation of the vigorous leadership of our distinguished chairman, the Honorable WILBUR MILLS. As our chairman, he encouraged the analysis of every viewpoint, weighed every recommendation, utilized every

suitable suggestion, to develop the best possible result. I am proud to have had a part in the drafting of this bill.

There are those who may find imperfections in our work, and imperfections there may be, but when related to the tremendous, far-reaching scope of the work, they become much less significant. This is a "good" law, a needful enactment motivated by high purposes for the general welfare of the elderly, the near-elderly and the elderly of the future.

I consider this bill the best improvement to social security since its enactment 30 years ago. Long overdue, this measure is designed to effectively remove the fear of "old age" which was the intent and promise of the original legislation.

In my district, and it is reasonably representative of a large urban district, there are over 100,000 people who live on social security benefits, actually and fully retired.

The question is raised as to how they manage. Those who have been reasonably provident and fortunate—have managed. Those who have suffered illness are indeed in a dreadful plight.

When the late President Roosevelt first talked about our freedoms he omitted a reference to the freedom of fear from illness. With the passing years the skyrocketing cost of hospital and medical care have multiplied this inherent fear of our elderly into a persistent nightmare.

In my community, the last opportunity for those over 65 to enroll under Blue Cross occurred almost 2 years ago. The rate for 70 days hospitalization insurance on that occasion was \$.95 per month. The rate was not related to costs and imposed tremendous burden upon the younger groups to subsidize the coverage for the elderly.

Since that time, the only available coverage occurred under the Ohio 65 plan which was sold for \$12.50 a month and paid hospital bills up to \$15 per day for a period of 31 days. The cruel fact of this offering was that there were no hospital rooms available in the community under \$38 per day thus leaving the so-called assured exposed to the colossal expenses not included in the coverage. A comprehensive policy under the Ohio 65 plan with substantial deductions was offered at \$23 per month or \$276 per year.

With average benefits totalling \$88.50 per month, just how would the average social security beneficiary be capable of paying for coverage which under many circumstances would cost 26 percent of his income. At these prices, adequate health insurance could only be acquired by reducing expenditure for other essentials such as food, shelter, and clothing.

A great deal is said about the cost of subsidizing hospital care of the aged through the payroll taxes of those who are working and the subsidizing of the medical care of the aged through general revenues. The simple fact is that the immense cost of this burden must be subsidized one way or the other. If these responsibilities are not handled through this type of a program, they

must be undertaken by citizens individually. There is no doubt that this is the most preferable way to meet this critical problem.

There is another important consideration. One of the prime purposes of social security is the creation of inducements to retirement. There are 1¼ million people in America today who continue in their jobs and who have not taken advantage of their retirement benefits although they are fully eligible. Hundreds of thousands of these workers who are eligible for retirement are reluctant to retire because of their grave concern of their capacity to pay for medical and hospital needs. This bill may provide the needed incentive for their retirement. It is possible that this bill could encourage the retirement of 300,000 or 400,000 persons who now hold job billets which are needed by others coming along.

The Government's cost of this program is minute when related to these increased job opportunities which this legislation may generate. Other agencies and other job-creating programs spend as much as \$5,000 to \$35,000 per job created. This bill can create these job billets at a fraction of the Government cost in other programs. These are permanent jobs and the billets will be created every year as workers are encouraged into a retirement where health and medical needs are assured.

In my community as in others throughout America, we will need additional hospital facilities. In my community at the present time there are no extended care facilities. We will have to undergo extensive construction programs to provide adequate extended care and hospital facilities. It is high time that America commenced an extensive and adequate program to provide these facilities. This construction will create jobs and contribute to the betterment of general economic conditions.

At the present time, the antipoverty program is shaping up throughout America to train and prepare the million of disadvantaged Americans who search for opportunities to work. This bill and its incentives will provide an area and need for trained hospital and medical staff workers who can be trained in the antipoverty program to do needful and necessary things for the aged and the infirm who need this care. No more worthy program could be developed. Now is the time to prepare these people for hospital and medical work. This bill therefore provides new areas for utilizing the antipoverty program and developing skills and manpower where they are most urgently needed.

The impact of this new bill will be far reaching. In the early stages, we must expect that the administration of this program will be difficult and perhaps disappointing. The success of the program will depend in great extent upon the cooperation of the medical profession which must ultimately develop policies directed toward the most effective hospital utilization and the most efficient and economical utilization of medical and nursing services.

No one can dispute the need for this program or the high purposes which impel its adoption. With early diagnosis and treatment, there is hope that good health in later life can be extended to the same degree that modern science has extended life itself. The senior health sciences will indeed be stimulated by this program which may ultimately provide every citizen with a longer, healthier expectancy. The years of good health we add to life, may indeed be our own.

Mr. BETTS. Mr. Chairman, I yield 8 minutes to the gentleman from Alabama [Mr. MARTIN].

Mr. MARTIN of Alabama. Mr. Chairman, at the outset of my brief remarks I would like to commend the Chairman and other members of the Committee on Ways and Means for the very able work they have done in preparing the Social Security Amendments of 1965. I would also commend them for the leadership they have lent to this debate. It is quite evident that we are not all in accord on how best to deal with the health care problems of the aged but no one can

deny the responsible and constructive manner in which this matter is now being considered.

As one who is not an expert in social security matters, I would have preferred that hearings be held on the specific legislative proposals now before us so that I could study that record. However, the committee report I think is most informative—both the majority and the minority views—and I commend those responsible for its preparation. My Republican colleague from Virginia [Mr. BROYHILL] merits special commendation for his additional separate views in which he comments on the reasons why he considers the eldercare approach superior to the medicare approach in providing for the health needs of our senior citizens. Mr. Chairman, as one who was privileged to be a cosponsor of the eldercare bill, I am grateful to my Virginia colleague for setting forth for the record his very significant statement.

Mr. Chairman, I would next like to comment briefly on some of the substantial provisions of this bill.

I approve of the increase in cash benefits provided under the bill. As I understand the matter, the last general benefit level increase occurred in 1958 and in the intervening period the cost of living has increased so that the OASDI recipients need this adjustment in their benefits. I would have preferred to see the minimum benefit raised somewhat higher than is proposed in this bill but I recognize the limitations that are imposed on any benefit increases by the requirements of actuarial soundness and restraint in use of the taxing power. I will have more to say on the tax aspects of this bill later in these remarks.

Another provision in the bill that I consider particularly meritorious concerns the liberalization of the retirement test so as to give greater discretion and flexibility to our aged in combining periods of retirement and periods of some work. I have always believed that our elder citizens should be encouraged to

continue some working activity in the interest of advancing their own well-being and the change in the retirement test will make that possible. Also, this retirement test improvement will increase the equity of the social security program as it applies to our individual citizens.

Mr. Chairman, I would like to commend the membership of the Committee on Ways and Means for including in this bill a provision continuing cash benefits with respect to children up to age 22 who are attending school. To the extent that this modification enables our young citizens to continue their education it will serve a very meritorious purpose. The provisions of the bill that strengthen the Kerr-Mills program of health care for our medically indigent are also very desirable and I am particularly pleased that the eldercare concept has been adopted by these changes.

But, Mr. Chairman, all is not good in this bill. There are some changes proposed in H.R. 6675 that I wish the committee had not proposed or I wish that the committee had decided to deal with in another way. An example of a change that I would like to see deleted is that provision which includes cash tips in the taxable wage base. My concern over this provision is that the administrative complexity it involves will outweigh the other considerations that prompted the committee to include it in the bill.

Mr. Chairman, I am opposed to the compulsory medicare provisions of H.R. 6675. As one of the sponsors of the eldercare bill I fully subscribe to the views of the gentleman from Virginia [Mr. BROYHILL] as they are set forth in the committee report. I object to medicare because it is needlessly compulsory and because it is financed by a regressive payroll tax that will reduce the take home pay of many people who cannot afford to pay additional taxes. Medicare threatens to involve our health services, our health professions, and our aged in a great bureaucracy that will impair the quality of our Nation's high medical standards. I also share the view expressed today that the inclusion of service-type benefits in the social security program may impair the ability to meet future cash benefit obligations. I will not belabor the point by reiterating the dangers and disadvantages that are inherent in the medicare approach to the problem of assuring that our aged citizens receive adequate health care. Suffice it to say that H.R. 6675 would risk these dangers and impose these disadvantages needlessly. There is a better way and that better way is clearly provided by the alternative being offered by the Republican members of the Committee on Ways and Means. I support that alternative and urge others to do so because of the many superior features this alternative approach provides. It is voluntary, more comprehensive in coverage, recognizes the principal of ability to pay, and is not financed by regressive payroll taxes.

Mr. Chairman, I am a businessman and have worked all by adult life in the competitive world of our free enterprise

system. I am also an employer. I know first hand what mounting tax burdens do to stifle the growth potential of business and the employment opportunities a growing business provides. It is in part because of my business background that I am gravely concerned over the payroll tax burdens that will result from this bill. We are proposing to take almost \$5 billion more in taxes next year just for social security purposes. The present \$17 billion that we now collect in social security taxes will almost double by 1972 and the total will continue to mount after that. Mr. Chairman, that is another reason why I am concerned over using the social security mechanism to finance medicare. I submit to my colleague there is a better way and we should adopt it. I will vote in favor of the motion to recommit H.R. 6675 with instructions to the Committee on Ways and Means to report the bill back to the House with that better way included.

Mr. MILLS. Mr. Chairman, I yield 3 minutes to the distinguished gentleman from Tennessee [Mr. FULTON].

Mr. FULTON of Tennessee. Mr. Chairman, during my campaign for the Congress in 1962 one of the most important pledges I made to the people of Tennessee's Fifth Congressional District was a promise to vote for the medical care for the elderly program. The year was 1962.

Last year, in 1964, it was necessary to renew that pledge because the House of Representatives had not had the opportunity to consider this program.

As a candidate it was my belief that commitment to this program was all I could offer.

However, it was also my belief that as a Member of this body I could contribute to enactment of this program in a more positive way if given the opportunity. On January 7, of this year, my Democratic colleagues gave me that opportunity by honoring me with a seat on the House Ways and Means Committee.

In the past several weeks it has been a privilege to sit with all the members of this committee in the deliberations which led to the writing of the bill now before us.

As a result of those deliberations, guided by the skilled and very able leadership of Mr. Chairman MILLS—with a rather surprising assist from some very unexpected quarters—the committee has reported this bill which goes much further in meeting health needs of our senior citizens as well as providing for their general welfare than any previously considered.

We also must recognize the contributions made to this bill by such organizations as the Senior Citizens, the AFL-CIO, HEW, and the millions of Americans who have lent their support by word, letter, and deed.

Members of the medical profession, hospital administrators, insurers, and other groups rendered constructive assistance by providing the committee with very useful information, facts and data.

It is a privilege and honor for me to rise in support of H.R. 6675. The programs and benefits in this legislation will contribute significantly to the solution

of one of the major social concerns of our time, the needs of the elderly. In addition, it will provide that priceless ingredient so important to secure retirement with peace of mind by eliminating fear of economic deprivation through major illness and medical expense which constantly nags at the hearts of millions of Americans who are 65 or older. This bill will also free millions of young Americans from the heavy financial burden they are forced to carry in financing the medical care of aged parents and relatives.

The CHAIRMAN. The time of the gentleman from Tennessee has expired.

Mr. MILLS. Mr. Chairman, I yield the gentleman 2 additional minutes.

Mr. FULTON of Tennessee. Mr. Chairman, some 2 years ago, there were three major programs which I supported in my campaign for Congress. Of those three programs one was the medical care for the elderly under social security, one was Federal aid to education, and one was equal opportunity for all of our citizens of the United States. Last year I had the pleasure of casting a vote for one of those major programs, namely, to give to every American equal opportunity. Only 2 weeks ago I had the pleasure of voting for another of those major programs in my campaign, that is, a bill to give Federal aid to education, and today I am looking forward, as we close debate on this bill, to casting a vote on the third major program which I promised the voter in 1962.

Mr. Chairman, once again it is an honor and a privilege for me to rise in support of this bill.

Mr. BETTS. Mr. Chairman, I yield 10 minutes to the gentleman from New York [Mr. HALPERN].

Mr. HALPERN. Mr. Chairman, I rise to support the comprehensive legislation for health care now before the House.

I believe without hesitation that passage of this bill as it stands reflects the opinion of the overwhelming majority of Americans. We are all familiar with the many years of debate which has preceded floor consideration today, and I would hope that we are about to reach a conclusive determination.

I do not wish to detail the various elements of the bill, with which I am sure my colleagues are familiar. The legislation offers four approaches: First, a hospital care program financed through increased payroll taxes; second, a voluntary plan covering physicians' surgical expenses and other health services; third, an extension of the Kerr-Mills program; fourth, improvements in the old-age, survivors, and disability insurance program.

The provisions are far reaching. There is no doubt that we are recognizing a Federal responsibility toward the medical care of the elderly, though it is clear that this responsibility was already established through Kerr-Mills.

Mr. Chairman, I have been privileged to sponsor and testify in behalf of like legislation through the years of my service in the Congress. Since 1959, when I was privileged to be associated with our former colleague, the distinguished

and beloved gentleman from Rhode Island, Aime Forand, in the sponsorship of legislation that pioneered the bill before us, I have participated in the continuing effort to win an effective health care program for the elderly. I cannot help but feel how thrilled our friend, Aime Forand, must feel today to see the cause he led so gallantly for years finally come within near realization. And it is significant to point out with the passing of time since the legislation's original introduction the urgency of realistically meeting the medical needs of elderly citizens has grown.

I dare say the bulk of testimony and record that has accumulated on this one issue probably outweighs any other. We know that today only one-half of the Nation's elderly hold hospital insurance; this percentage consists predominantly of the very old, those in poor health, the unemployed, and those with the lowest incomes.

And for those who are enrolled in commercial plans, the coverage is wholly inadequate to meet spiraling medical costs. The Special Committee on Aging of the Senate reported in July 1964 that only 1 in 4 older people hold insurance which the American Hospital Association claims as adequate.

A Bureau of the Census survey indicated that where one or both spouses had been hospitalized during 1962, couples had total medical expenses approximating \$1,200, of which \$600 represented hospital costs. By this accounting, half of the medical expenses of the aged are nonhospital items, and coincidentally, these items are precisely those which are inadequately covered through commercial plans.

Thus the supplementary and voluntary approach for nonhospital services in H.R. 6675 is appropriate and necessary. The committee estimates that above the annual \$50 deductible, the plan will cover 80 percent of the patient's nonhospital treatment.

We know that hospital costs represent a substantial portion of the retiree's medical expenses. The average cost per day for inpatient care, including room, board, and miscellaneous laboratory and medication fees, reaches \$40 or more. Hospital expenses have risen about 7 percent every year during the 1960's. The elderly use hospitals about three times as much annually as younger people in other age brackets.

Mr. Chairman, in summary, we are dealing with an age bracket wherein the need for health care is most acute, but where the resources to meet the need are most lacking. In most cases, medical care represents an overwhelmingly large slice of their annual budgeting. And we are similarly aware that millions of people are unable to afford the kind of treatment they need.

In 1960, 45 percent of those over 65 had an annual income of less than \$1,500. In this bracket there is almost a total lack of alternative financial resource in case of emergency.

There are endless statistics indicating the stringent demands of the elderly for health care they simply cannot afford.

H.R. 6675 similarly raises the benefits to a minimum \$4, and also increases the permissible outside earnings for those receiving benefits. Widows at age 60 would become eligible for actuarially reduced benefits.

I am especially pleased that the bill contains a provision extending child's insurance benefits to age 22 to children attending school or college beyond the age of 18. Last year and additionally in the present Congress I introduced amending legislation to accomplish this just objective, and it will greatly assist young widows with children who are faced with financing higher education; we know the ever-expanding urgency of education as a prelude to employability. This provision will take effect on January 1, 1965, and approximately 295,000 children will become eligible for these education benefits.

H.R. 6675 additionally corrects an inequity which has long burdened an important employee segment of the economy. Tips paid an employee have always constituted taxable income; yet the Social Security Administration has been reluctant to consider tips as wages for social security purposes. Since a waiter's salary is depreciated in adjusting to tips, he has found himself in the lowest social security scale. H.R. 6675 rectifies this injustice by providing for the reporting of tips for social security purposes.

In returning momentarily to the health care portions of the bill, H.R. 6675 additionally authorizes \$5 million for fiscal 1966 for child health and maternal services; amounts are authorized for crippled children's service and for grants to educational institutions to train professional personnel in the care and health of disadvantaged, particularly retarded, children. HEW is authorized to initiate a 5-year program, in cooperation with State health authorities, for projects providing broad health care to children of especially low-income families.

Mr. Chairman, this is comprehensive legislation offering the Nation's elderly the whole panorama of health care so that they may live out their lives in reasonable comfort and dignity. I am convinced that the bill does not jeopardize the valued and important doctor-patient relationship; the choice of doctor is left completely to the enrollee. The bill does give the aged the necessary resources to secure needed medical care, and I do not believe this violates any professional or private ethic.

This Nation has advanced momentarily in the field of medical science. No other people can boast of comparable knowledge and facilities. The cost of this expertise is steadily increasing. Does this mean that only the well-to-do, only those with sustained income in their later years, are eligible to receive health services? Illness does not discriminate between rich and poor, though we do know statistically that lower income families are more susceptible to almost every kind of sickness.

Medical attention, I must insist, is not a common retail commodity. In the final analysis we are dealing with peoples' lives, and with the health of the

body politic. This is the real issue. We have amassed steadily distressing evidence that the overwhelming majority of older people cannot afford proper care when illness and emergency strike, and this is a legitimate interest of the national government.

The system prescribed in H.R. 6675 can work if we apply it intelligently and with prudence. I urge the House to take this necessary step and pass this legislation.

Mr. HORTON. Mr. Chairman, will the gentleman yield?

Mr. HALPERN. I am pleased to yield to my distinguished colleague, the gentleman from New York.

Mr. HORTON. Mr. Chairman, I take this opportunity to rise to commend the chairman of the committee and the members of the Committee on Ways and Means for the excellent work they have done on this bill and also to take this opportunity to indicate my support for H.R. 6675.

THE PROBLEM

The primary problem of America's senior citizens is how to meet the costs of health care at a time when income is lowest and potential or actual disability is highest.

Two factors are present in this problem. First, the aged population of our country is growing considerably; there now are approximately 18 million people in the United States who are over the age of 65. Second, rapid progress in medical science has not been paralleled by the economic progress of older citizens; they are caught in an increasing squeeze between sharply reduced income in retirement years and increased medical expenses.

Let us look for a moment at the dimensions of this second factor, namely, the heavy medical costs of old age when incomes typically are low.

Based on comparable family circumstances, income for the over-65 age group is less than half that earned by younger people; yet, health costs for the older Americans are twice as much. Fully half of the aged couples have incomes of under \$2,800 annually. The average senior citizen living alone—and one out of every four over 65 does—has little more than \$1,200 a year.

On the other hand, medical care costs have doubled since 1947. Daily hospital service charges have tripled during that same postwar period. Additionally, hospitalization insurance premiums have shown a 100-percent increase since 1952, an increase greater than any other important item in the consumer price index.

The reasons for these higher costs are real. New advances in the healing arts—new medical techniques, new drugs, new progress in therapy—have multiplied man's ability to control and conquer disease. Still, these strides have been expensive and part of the expense must be borne by the beneficiaries.

As would be the expected result of this imbalance between science and economics, the impact of higher medical costs is felt most heavily by the aged. They require more medical services than the younger population and for longer times.

Statistical evidence reveals that four out of five people over 65 have a disabling or chronic condition. Further, they go to the hospital more frequently and stay twice as long as those in the under-65 population.

Among the aged of this country, there is very little freedom from the fear that serious illness will wipe out their financial resources. The choice is between going without needed medical attention or exhausting their savings for it and then living out their lives dependent on others or as public charges. I think we can agree this is not a desirable choice.

PROPOSED SOLUTIONS

For the past 20 years, there have been proposals before Congress to establish some system for national health care.

In 1950, the Social Security Act was amended to authorize Federal participation in the cost of medical care benefits made available to the needy aged under State and local welfare programs. Several times since then Congress has extended and expanded Federal support of these programs.

The most significant of these improvements was the Kerr-Mills Act of 1960. This authorizes matching payments to the States to aid in financing medical care for aged persons. An individual's eligibility is based on a means test and administration is through public assistance agencies. These two elements of Kerr-Mills are considered its chief stumbling block.

Therefore, proposals for a national health insurance program financed by payroll deductions, similar to social security, have been heard more and more.

These measures for a health care program financed under social security commonly are called medicare. But while the name is the same, their legislative language over the years has varied widely. Since 1961, this kind of legislation, also, has carried the name King-Anderson, after its two principal congressional sponsors.

THE PENDING PROPOSAL

While H.R. 6675 has medicare in it, it also is much more. In fact, the bill is a five-part measure.

The first part deals with hospital and nursing home care for our elderly citizens. These benefits would be paid out of a separate trust fund to which payments would be made from payroll deductions. It is strictly a hospital insurance program. No doctors' bills or other related medical services are included in the benefit provisions made available by this part.

The second part of the bill offers older people the opportunity to participate in a medical insurance program to help them pay physicians for the cost of treatment. This is voluntary. If a person wants this coverage, he signs up for it, pays a monthly premium, and the Federal Government matches his contribution from general revenues.

The third part revises and improves the benefit and coverage provisions of the present social security old-age, survivors, and disability program.

The fourth part expands existing provisions of medical assistance for the needy aged. It will bring better benefits

to more people through Federal-State cooperation.

The fifth and final part deals with added amounts of money to be provided the States from the Federal Treasury to serve mentally retarded, maternal and child health, and crippled children programs.

At this point, I would like to highlight the principal provisions of each part.

PART 1—BASIC HOSPITAL INSURANCE

The plan would pay for—

Inpatient hospital services for up to 60 days for each period of illness, with the patient paying the first \$40. All services usually furnished by a hospital are covered;

Posthospital care for up to 20 days per illness after a minimum of 3 days in the hospital. For every day the person's hospital stay was less than the 60 days, he would be eligible for 2 additional days of this nursing home care, up to a maximum of 80 days.

Outpatient hospital diagnostic services. The patient would pay the first \$20 for these services provided by the same hospital during a 20-day period. If within 20 days of his receiving such services, he should become a hospitalized patient, the \$20 would be credited against the first \$40 requirement.

Up to 100 home visits for health care by a visiting nurse or similar specialist after the patient was discharged from a hospital or nursing home.

Under the terms of the bill, the hospital benefits would become effective on July 1, 1966, and the other benefits on January 1, 1967.

The financing of the program would come from a payroll tax levied uniformly on employers, employees, and the self-employed.

It would begin at 0.35 percent in 1966 and increase to 0.80 percent by 1987. Additionally, the earnings base to which the tax would apply is increased from the present \$4,800 to \$5,600 a year in 1966 to \$6,600 in 1971.

For those not covered by social security or railroad retirement, general revenue would support the system.

The payroll taxes and general revenues go to a separate hospital insurance fund in the Treasury.

Administration of the plan would be by the Health, Education, and Welfare Secretary with assistance from the States and private organizations and advice from an Advisory Council created by the bill.

PART 2—SUPPLEMENTAL MEDICAL INSURANCE

This is a voluntary plan to provide physicians and other medical and health services. Three-dollar monthly premium payments by individual participants would be matched equally by the Federal Government out of general revenues, and after an annual deduction of \$50, would pay for 80 percent of these costs—

Doctors' and surgeons' services provided in the hospital, clinic, office, or home.

Other medical and health services, in or out of an institution, including X-rays, laboratory tests, EKG's, basal metabolism readings, radium and isotope therapy, surgical dressings and casts,

artificial limbs and eyes, certain ambulance services, and certain equipment rentals.

Hospital care for mental illness up to 60 days per confinement, with a maximum lifetime benefit of 180 days.

Up to 100 home visits each year with no prior hospitalization requirement.

A social security allotment is authorized for payment of the individual's \$3 monthly premium payment.

The bill sets up periods for enrollment in each odd-numbered year from October 1 to December 31. Special periods also are established at the start of the program. The benefits would become effective on July 1, 1966.

Again, the Secretary of Health, Education, and Welfare would be responsible for administration of the program. Private insurance carriers, under contract, would carry out the major administrative functions, such as determining rates of payment and fund disbursement.

A separate section of the supplemental plan also affords a tax deduction for taxpayers of all ages amounting to one-half the cost of premium for medical care insurance. This would be in addition to presently permitted deductions for medical costs.

PART 3—SOCIAL SECURITY

The 30-year-old social security program of monthly benefits for those who are retired, disabled, or survivors is improved under H.R. 6675. Benefits are increased across-the-board for some 20 million people. They would be made retroactive to January 1, 1965.

In terms of dollars, the monthly benefit range for 1965 would go from the present \$40 to \$127 to a new \$44 to \$135.90. In 1966, the maximum monthly payment would increase to \$149.90. In 1971, it would be \$167.90.

Additionally, the bill sets these new benefits—

Continuation to age 22 for covered children where the beneficiary attends school full time. The present age limit is 18.

Widows' eligibility beginning at age 60, rather than 62.

Disability coverage if a covered worker has been totally disabled for 6 consecutive months.

Reduction of minimum covered work requirement for people 72 and older or their widows.

Increased outside earnings limitation and the exemption of certain income for determining earnings.

Coverage for divorced wives or widows if married to an eligible worker for at least 20 years.

New coverages also are added in the bill. These take in self-employed physicians, farmers, and those employees receiving tip income.

The bill revises the rate schedule for employer-employee contributory financing in graduated steps from the present 3.6 to 4.8 percent by 1973. In line with the basic hospital insurance section, the annual earnings base for computation of payroll deductions is enlarged from the present \$4,800 to \$5,600 on January 1, 1966, and to \$6,600 in 1971.

I want to point out that the provisions in this social security section of H.R.

6675 are very comparable to those I offered on February 17 with my introduction of H.R. 5039. These provisions in many respects are based on the bill we passed here in the House during the 88th Congress and which also cleared the Senate in the last Congress. Of course, that measure never left conference owing to the disagreement over the Senate's addition of a health benefits amendment.

PART 4—KERR-MILLS

Another principal section of this bill extends and expands the existing Kerr-Mills program of Federal assistance to State programs providing medical help to needy older people. This enlargement will be used to increase the Federal matching share from the present maximum of 80 to 83 percent, and also to cover medical costs for the needy who now receive help under the dependent children, blind, and disabled programs.

PART 5—CHILD HEALTH AND PUBLIC ASSISTANCE

The bill provides more Federal funds for a number of child health programs presently authorized and also adds new care and services for youngsters from low-income families. The Federal share for all State public assistance programs is increased. Further, the present limitation on Federal participation in public programs aiding patients in tuberculosis and mental hospitals is removed.

COMMITTEE ACTION

The Ways and Means Committee brought forth H.R. 6675 as a more comprehensive measure than any one of the single legislative proposals which had been introduced for Committee consideration. And, there were many proposals.

In some senses, H.R. 6675 borrowed from a number of the plans proposed for aged health care.

The Byrnes bill to establish a national health insurance program for hospital and medical care is found in the supplemental system of insurance for doctors' services. While this bill also sought a similar system for hospital care costs, the committee chose a payroll tax for this area.

Thus, a dual approach is in H.R. 6675: basic hospital care is financed by a payroll tax to let a person in his working years pay into a trust fund; and for supplemental medical care, the individual can elect to contribute into an insurance fund when he gets to be 65, putting up one half the cost of premiums and having the Federal Government match that from general revenues.

I understand the committee also considered the eldercare proposal for a health insurance program in which general revenue funds from the Federal Government could be used to match State grants to buy private insurance coverage. This plan requires the individual to participate in the premium payments based on his means.

But, eldercare is not before the House for a vote, save for its suggestions on Kerr-Mills expansion to the needy aged. These, as I have outlined, are very much a part of H.R. 6675.

Other programs, too, that came before the committee are not up for debate and decision. The question then is whether H.R. 6675 shall be accepted or rejected.

CLOSED RULE

This "take it or leave it" situation is the result of the parliamentary procedure customarily employed for House consideration of tax, tariff, and social security legislation. In order to ward off piecemeal amendments that could threaten the overall structure of such complex bills—and H.R. 6675 runs 296 pages—the rule allows no amendments.

There is, in the so-called motion to recommit, one opportunity to alter a bill considered under a closed rule.

In this instance, the motion to recommit would substitute in place of the basic hospital insurance plan—which H.R. 6675 finances via a payroll tax—the type of financing found in the bill's supplemental plan; namely, premium payments by those over 65 to be matched from the Treasury and on a voluntary participation basis.

Because the basic plan is intended as a minimal benefits plan—a floor of coverage—I believe the bill's basis is sound and sensible. It is not comparable with the supplemental medical insurance section and should not be intermixed.

As I pointed out earlier, there is a priority need to set a minimum standard for basic hospital care available to all older Americans. Because it is so fundamental, I believe it clearly fits our concept of providing Government-protected insurance, financed during working years for security in retirement years.

Prolonged hospitalization imposing a despairing drain on personal and family resources is the one single threat to our present pensioners which to date we have not solved satisfactorily. To insure their independence, I feel it is appropriate and accurate to build this floor of coverage through the formula of payroll deductions into a separate and distinct insurance fund.

FINAL PASSAGE

Mr. Chairman, I believe in the merits of this measure. I believe its passage will create a climate and condition of new security for millions of senior Americans.

The enactment of H.R. 6675 will establish a meaningful program of hospital and medical insurance for the elderly and a series of other benefits for the general good of our Nation.

Therefore, I shall vote for it and work for its strength and soundness in the days to come.

(Mr. HORTON asked and was given permission to revise and extend his remarks.)

Mr. MILLS. Mr. Chairman, I yield 5 minutes to the distinguished gentleman from Florida [Mr. HERLONG].

(Mr. HERLONG asked and was given permission to revise and extend his remarks.)

Mr. HERLONG. Mr. Chairman, I had not intended to speak on this bill and I do so even now with some reluctance.

Mr. Chairman, I certainly do not mind speaking out what I think on a matter, and with reference to the statement made by the gentleman from Tennessee [Mr. FULTON] a few moments ago as to the measures on which he campaigned, I must say that I campaigned in the congressional district, which it is my honor

to represent, on the opposite side of each one of those three issues, and we are both here. So that does not prove a thing.

Mr. Chairman, the provisions of this bill have been pretty well covered both pro and con in the debate and anything that I will say will certainly, at least to a degree, be repetitive.

Mr. Chairman, my problem with reference to this bill is not one of whether we should go into a program of medical and hospital assistance. Even though it is going to be an expensive program, I believe it is necessary. Any doubts that I have about this bill stem from the method of financing the hospital care portion of it.

Mr. Chairman, I have never believed that hospital care should be financed through social security taxes. I have had some very illustrious company in my beliefs, including the beloved and distinguished chairman of our committee. This bill sets up a slightly different approach in that there is a separate trust fund and the tax is not called a social security tax. What name is bears, however, does not make any difference. It is, as is social security, a payroll tax and as such bears more heavily in proportion to income against people in the lower income brackets. I do not see how so many people who are in these lower brackets could be sold on the idea that they should pay a proportionately larger part of the bill, especially when a part of their money will be used for the purpose of paying hospital bills for people who are well able to pay these bills themselves. This simply cannot be justified to the workingman back home—and I for one do not believe that the majority of them do favor this method of financing.

If there is a problem in this area, and there is, it is a problem of all the people in this country, and it should be paid for by all of the taxpayers in this country. I am in favor of the across-the-board social security increases. I am in favor of most of the other social security provisions that have been added to the bill. I like the voluntary insurance program and expansion of the Kerr-Mills program that are included, but I still do not like the very unfair payroll tax method of paying for hospital benefits.

I therefore expect to vote for the motion to recommit, which gives all the benefits I favor, but does not include the payroll tax method of financing.

Mr. BETTS. Mr. Chairman, I yield 10 minutes to the gentleman from Ohio [Mr. LATTA].

(Mr. LATTA asked and was given permission to revise and extend his remarks.)

Mr. LATTA. Mr. Chairman, H.R. 6675 is a three-part bill and this House should have been permitted to have worked its will on each one of its parts. For this House to be denied the opportunity to amend such a comprehensive bill—denied even the opportunity to strike one of its titles—is beyond belief. The Democratic-minded American people will never believe it. I well realize that our Democrat friends hold more than a 2-to-1 majority in this House, that they have a 2-to-1 majority on all com-

mittees, that they have the votes to demand and receive the "gag" rules they want from the Rules Committee for the consideration of any bills, and that they have the votes to pass any legislation—in the form they decree—they want to pass. These matters were decided in a majority of the congressional districts by the electorate in those districts last November. However, in making this decision, I doubt very seriously whether they voted for this House to abdicate its responsibility to at least properly consider and amend legislation before "rubberstamping" it.

Certainly the American people will long remember the procedure being used to pass this compulsory, limited hospitalization plan often referred as "medicare." Every working man and woman will remember the sharp increases in social security taxes called for in this bill. These good people will be asking—as I am asking today—why the administration and the medicare backers were afraid to let this so-called medicare part of this bill come to the floor of the House by itself—or at least under a rule permitting amendments—and be voted up or down on its own merits. What were they afraid of? If this is such a good plan, it could have withstood House scrutiny and amendment. Instead, medicare has been made a part of a comprehensive three-part bill labeled the "Social Security Amendments of 1965," making it necessary for a Congressman to vote yes on medicare in order to be recorded as voting yes on the other two parts of this bill and presented to us under a no-amendment rule.

Personally, I favor the title in this bill which amends the existing Social Security Act and increases benefits. The House passed a bill last session which I supported containing most of the amendments provided for under this title. Unfortunately, these benefits were denied our social security recipients last year when the bill died in the conference after the administration insisted on attaching medicare to it. In fact, I favor a greater increase in social security benefits than the 7-percent increase with a \$4 minimum as provided for under the bill we are now considering. However, the "gag" rule which has been imposed upon us by the Democrat majority precludes us from even attempting to increase these benefits. Now, may I ask how much good will a \$4 a month increase be to a social security recipient in these inflationary times? Anyone who has been to the grocery store lately can answer this question.

I also favor the other title in this bill which incorporates the Republican plan to permit our senior citizens to subscribe to a voluntary insurance program to pay physicians' and other medical and health services at a cost of \$3 per month. Why the administration has agreed to a voluntary medical program—the cost of which is not placed on the working men and women through increased social security taxes and has steadfastly insisted on a compulsory hospital plan financed by higher social security taxes is more than I can understand.

Mr. Chairman, I have just sent a questionnaire into my district posing questions on this legislation and I can say without a shadow of doubt that a great majority of the people in the Fifth District of Ohio do not favor a compulsory hospitalization plan financed by increased social security taxes. In fact, of the more than 15,000 questionnaires already returned to our office, not quite 20 percent of those voting in favor of a hospitalization plan favored medicare. When one considers that almost 43 percent of those returning questionnaires to date indicated they did not favor any interference by the Federal Government into this field, you can readily comprehend how little support there is in the district for this compulsory medicare plan. Now, why do they object? First, the people of the Fifth District of Ohio dislike compulsion. Second, the working men and women object to the increase in social security taxes. Third, the people of the district fear that medicare will lead to socialized medicine and a decrease in the quality and availability of medical and hospital services. Mr. Chairman, I could comment at length on each of these objections but the time allotted me will not permit. Let it suffice then for me to say that I know how much it costs to maintain a family and I know that a family man making \$5,600 annually cannot afford the overall \$69.60 increase in his social security taxes next year as called for in this bill. Neither will he be able to pay \$323.40 in social security taxes in 1971 if his earnings reach \$6,600.

If this administration is bound and determined to saddle the country with its medicare plan, the least it could do would be to find some other method of financing it instead of putting it on the backs of our working men and women and those responsible for their jobs. The administration could even do the unexpected and call a halt to some of its wasteful spending and finance it out of current revenues.

Mr. Chairman, I am deeply sorry that the parliamentary situation under which we are operating will not permit a vote on the eldercare bill by this House. The people in my District voting for a hospitalization plan overwhelmingly favored eldercare over medicare. I would have liked the opportunity to cast my vote for eldercare. This opportunity will not present itself today. I, therefore, intend to support the motion to recommit this bill to the Ways and Means Committee with instructions to substitute the voluntary Byrnes hospitalization plan for the medicare title and to include the other two titles of H.R. 6675. Everyone in this House is well aware of the fact that the motion to recommit will be the crucial vote on this bill. The vote on final passage will be anticlimactic as this bill is going to pass—with or without my vote. Believing as I do that medicare is the first step towards socialized medicine in America, I intend to vote "no" on final passage. I do so with great reluctance as I am in favor of the other two titles in this bill but the "gag" rule under which we are considering this bill has made it impossible for me to cast

my "yea" votes for them. To do so by voting for medicare, is a condition I refuse to accept.

Mr. MILLS. Mr. Chairman, I yield such time as he may require to the gentleman from Ohio [Mr. FEIGHAN].

Mr. FEIGHAN. Mr. Chairman, I congratulate the very able and distinguished chairman, the gentleman from Arkansas [Mr. MILLS], and the members of the Ways and Means Committee for bringing H.R. 6675 before the House for action.

This legislation results from many months of public hearings and thorough study of all the issues involved in meeting the most urgent medical needs of the aged. To say that the purposes of this legislation have been the subject of long, at times, bitter controversy, is to understate the case. To say that the legislation now before the House represents substantial improvements in actual benefits, over and above the proposals set forth in the medicare bill, is a fair statement of the case.

The able chairman of the committee, Mr. WILBUR MILLS, deserves the gratitude of millions of Americans whose need for the medical services provided for in this legislation is well known. They have waited long for this action by Congress, and they have worked diligently to turn the spotlight of truth on all aspects of the problem. Their patience and their labors are about to be rewarded by enactment of forward-looking legislation pointed at providing a remedy for the most urgent medical needs of our senior citizens.

H.R. 6675 provides for a coordinated approach for health insurance and medical care for the aged under our time-proven Social Security Act. The basic plan gives the aged protection against the costs of hospital and related care. This is supplemented by a voluntary plan which provides payments for physicians and other medical and health services. Through this method the individual has a free choice as to the extent of medical insurance desired while at the same time being protected against the basic and larger costs of hospitalization and related care.

The bill also provides for expanded medical assistance programs for the needy, including the aged, blind, disabled, and families with dependent children.

These provisions alone argue for the passage of H.R. 6675. Some 17 million insured individuals and 2 million uninsured will qualify for the basic benefits involved by July 1, 1966. Further, an estimated 8 million needy persons will qualify for new or increased medical assistance, through the revised Kerr-Mills program.

H.R. 6675 provides other benefits through long overdue changes in key provisions of the Social Security Act. During the 88th Congress and again in this Congress I have introduced specific legislation to:

First. Increase widow's benefits and benefits to surviving children of deceased insured workers.

Second. Permit payments of child's insurance benefits after the age of 18 years in the case of a child attending school.

Third. Increase allowable earned income by retired workers.

Fourth. Increase old-age survivors and disability insurance benefits.

H.R. 6675 incorporates these changes which I have sponsored. It provides for an across the board increase of 7 percent in benefits to widows and surviving children and to old-age survivors and disabled persons. It is estimated that 20 million Americans will be the beneficiaries of this increase in monthly payments. The change authorizing payments of child's insurance benefits after 18 years and up to the 22d year, for those attending school, is expected to help 295,000 surviving children of deceased workers. By raising the ceiling on allowable earned income of retired workers, conditions of life for many of our aged citizens will be substantially improved.

I thank the committee for its favorable action on these amendments to the basic provisions of the Social Security Act. They are in tune with the times, they are realistic in terms of the needs of our people, and they deserve enactment by this Congress.

For these reasons I will vote for and urge passage of H.R. 6675.

Mr. MILLS. Mr. Chairman, I yield such time as he may desire to the gentleman from Missouri [Mr. RANDALL].

(Mr. RANDALL asked and was given permission to revise and extend his remarks.)

Mr. RANDALL. Mr. Chairman, I rise in support of H.R. 6675 as reported by the Committee on Ways and Means.

Before proceeding further, I wish to express my appreciation on being given this time to express some thoughts in connection with this measure. First, I think our great chairman of the Committee on Ways and Means deserves the commendation of everyone because of the leadership he has exhibited these last few days and because of the years of hard work he has devoted to hearings upon the several different proposals for hospitalization insurance and medical care for our senior citizens. Compliments are also due every member of the Committee on Ways and Means for the several months of hard work they have just finished. They have reported a bill that most Members will find it possible to support.

Correspondence on the general subject of medical care for the elderly has been coming into my office in substantial volume during each of the 6 years I have been a Member of the Congress starting with the Forand bill back in 1959. This mail has not simply been in an amount of hundreds but in the volume of thousands of letters. In answer to this large volume of correspondence I have tried to be consistent over the years when I have repeated I would not blindly oppose legislation of this type because in my opinion its passage was inevitable. Instead, I have said I would try to contribute to an improvement of these measures in a way or manner that would be acceptable to those who had written in opposition. In most of this mail I pointed out I thought there was some room for an improved plan of administration and that there should be

all means be some alternatives, choices or options left to the recipient and the entire plan should not be compulsory without the benefit of some preference of selection or latitude as to choices. As the hearings of the last 2 months progressed, it became apparent that the committee would request a closed rule and that this would mean Members would be cut off from offering amendments to the bill when it reached the floor of the House. Knowing this might be the case, the only avenue that remained was to urge the members of the Ways and Means Committee to set up alternatives or choices within the framework of the legislation, before finally reporting it from committee.

Over the past weeks I have made repeated contacts with members of the committee urging such optional plans. It is my belief that dozens of other Members of the House followed this same procedure. Anyway, the Ways and Means Committee finally came up with a bill that provided not only for basic hospitalization program but also set up an optional or voluntary supplementary medical program which was made available on a purely voluntary basis regardless of whether or not a person were eligible for social security or railroad retirement or other benefits.

While the cost to the individual was established by actuaries to be \$3 per month a person was left free to participate in this program or refuse it and certainly there was nothing about this part of the plan that was in any way compulsory or involuntary. Under the supplementary plan, the Secretary of the Department of Health, Education, and Welfare is authorized to enter into an agreement with any State before July 1, 1967. The bill provides that either a State agency may act as a carrier in the State with respect to this supplementary plan or may enter into an agreement providing for another carrier so that insurance benefits, coinsurance and other items can be paid under the benefits provided in the supplementary plan.

I am sure that all of you who had preferred the inclusion of alternatives are thankful and grateful to the committee for the form and content of the measure they reported.

Almost any proponent would admit the bill is not perfect. As a matter of fact that is true of nearly everything in the world. There are not very many diamonds that are exactly perfect. Just about every one of them has some kind of a flaw. Our brilliant sun which is the center of our solar system is not perfect. It has its sun spots. There is so much good in this bill that it is like a large piece of gold surrounded by some of the baser metals. The gold will never rust. It will always be there to shine through. In like manner, the great merits of this bill will always shine through its slight imperfections.

In some recent correspondence I received in my office writers have suggested I had already reached a decision and it was useless to write in opposition. Well, as I have stated over the years, I favored some kind of a workable plan. But my mind was never made up until

this bill was finally reported and until after I had an opportunity to study all of it and in particular its three principal parts including the basic hospitalization program; the optional supplementary medical program and the other provisions including increased social security benefits and liberalized disability benefits as well as improvement in the Kerr-Mills program. But after a clean bill was filed as H.R. 6675 and the accompanying report was printed the longer I studied it with its many, many beneficial provisions the better it seemed to become.

Mr. Chairman, one wonders quite frequently whether any of the debate here in the Committee of the Whole ever changes the viewpoint of a single Member. Yet I have a feeling this bill might be an exception because I know I have talked to several Members who are sort of on the fence or wavering whether to vote for or against this bill on final passage. Many of them would prefer to be in favor of the bill but their mail has been so heavy in recent weeks against the committee report and in favor of what has been called eldercare or in favor of the Byrnes substitute that they have considered opposing the bill on final passage.

Over the years I am certain the majority of those who corresponded with this office have favored some type of health plan for the elderly. In recent weeks, those in favor have neglected to write and our mail has been quite substantial against this bill. Some have freely and frankly admitted they have been asked to write by their physician. Others have joined in a petition that has been circulated by office employees or clerks in the offices of physicians. Some of the letters came from those who have been urged to write by their physician and state quite candidly and freely they have not had a chance to become familiar with the entire content of the bill but nonetheless went ahead to urge our opposition.

Although I have answered all of these letters I would like to say for the record that it is my opinion that these same people who are now opposed because they have been asked to be opposed by someone, will later become more familiar with the provisions of this bill. After it has been fully explained to them, I predict they will be glad the bill was passed by the Congress.

I hazard the prediction when these very same people who are opposed today to the bill because of lack of information about it, will in a short while learn about the layer after layer of benefits it contains. They will discover there are so many good provisions in H.R. 6675 that these people who have in recent weeks voiced their opposition will in the months ahead say that they were wrong and be truly grateful that the bill passed this body and is on its way to becoming law.

To enumerate a few of the provisions these include an increase in social security benefits by 7 percent; the establishment of a new minimum; the optional benefits for widows at age 60; the liberalization of eligibility requirements for about 155,000 presently disabled

workers; increase maternal and child health services and for crippled children's service. Even the Kerr-Mills program was extended and expanded to include not only the indigent aging but added the requirement that States provide a flexible income test for eligibility.

Yes, Mr. Chairman, when more people become more familiar with the multiplicity of benefits contained within the several parts of this bill all of which contribute to supplementing its major provisions, I would say to those Members who may be harboring the thought of voting against this bill you will be held accountable or responsible for participating in an effort to deny to the people all of these good things.

It is my considered opinion that before too long the present opponents will wake up to the good things they have not been told about in this bill and when they do they will never forgive those Members who are against this bill today.

Mr. MILLS. Mr. Chairman, I yield such time as he may require to the gentleman from California [Mr. CAMERON].

Mr. CAMERON. Mr. Chairman, I want to join with my many colleagues who have today paid tribute to the chairman of the Ways and Means Committee, the gentleman from Arkansas [Mr. MILLS]. He and his committee have truly brought before the House a monumental piece of legislation that will virtually enshrine his and his committee's efforts in the hearts of all Americans.

I also would like to pay tribute to you, Mr. Chairman, for the manner in which you have conducted this Committee of the Whole House, and the honor that your chairmanship pays to your late, esteemed father. I remember full well, when shortly after I was discharged from the Marine Corps in 1946, joining a speaker's bureau on behalf of similar legislation which your father had introduced in this body. I am sure that as the Committee rises tonight you will feel a sense of satisfaction, knowing that the work which your father began over 20 years ago has finally come to fruition.

Mr. Chairman, though I am a wholehearted supporter of this legislation in all of its facets, I would like to call to the attention of the House one slight defect in the measure of which I am aware. My discussions with members of the Ways and Means Committee and with staff thereof clearly indicated that it was the intent of the committee to provide appropriate language in each required instance to assure that the American people will have the opportunity of free choice with respect to vision care. Throughout this bill, there are a number of places where provisions have been made to allow the beneficiaries of the legislation to determine their choice as to disciplines which will meet their vision needs.

Most Members are fully aware, from the debate that surrounded H.R. 12 during the 88th Congress, of the continued rivalry between medical doctors who practice ophthalmology and doctors of optometry. In order to assure that the American people have a free choice of vision care, it has been necessary to specifically stipulate in all legislation

dealing with health care that beneficiaries may choose between optometry and medicine for this service.

Unfortunately, there is an area in H.R. 6675 that does not make this choice clear. The way section 532(b), which appears on page 150 of the bill before the House, is drafted precludes this choice of vision care for some 10 million school-children. Certainly, this inadvertency is understandable in drafting such a monumental piece of legislation. I am sorry that it is not possible to make a correction of this here on the floor. As you know, Mr. Chairman, the bill is being considered under a closed rule and, therefore, it is not possible to amend. I would hope, Mr. Chairman, that the clear intent of the committee and the expressed will of Congress over the years with respect to providing this very necessary option to all beneficiaries of governmental medical programs would be corrected in the Senate. Surely, amendments will be made to this bill in Senate committee. It seems to me that this should be one of the first orders of business when the bill reaches the other body. I know full well from past history on this same subject that there would be no hesitancy on the part of this body to accept such an amendment coming from Senate-House conference.

Again, Mr. Chairman, I pay tribute to you, to the chairman of the Ways and Means Committee, to the members of the committee and to the staff who have today given us the opportunity to vote on what will surely be among the most significant pieces of legislation enacted during the tenure of any Member.

Mr. MILLS. Mr. Chairman, I yield such time as he may require to the gentleman from New York [Mr. RYAN].

(Mr. RYAN asked and was given permission to revise and extend his remarks.)

Mr. RYAN. Mr. Chairman, this is indeed an historic day—the day when the House will finally approve of hospital care for our senior citizens through social security. I want to join in commending the distinguished chairman of the Ways and Means Committee for his leadership on the floor yesterday and today.

Social security was originally enacted 30 years ago, and no legislation since then has taken such sweeping steps toward insuring our Nation's health and welfare. I have been fighting for this kind of legislation throughout my service in Congress. At the opening of this session of Congress I joined our distinguished colleague, the gentleman from California [Mr. KING], in sponsoring H.R. 1, the well-known King-Anderson bill. In the 87th Congress I signed a discharge petition in an effort to bring the King-Anderson bill to the floor for a vote. Now it is here as part of a bill which will broaden and improve the whole social security program. H.R. 6675 is, as President Johnson said, "a tremendous step forward for our senior citizens." But it is more than that. It is a recognition of our society's growing awareness that with our riches and abilities we can, and we must, insure all American citi-

zens at least a minimal opportunity to the pursuit of health, life, liberty, and happiness.

Mr. Chairman, in 1957, our former colleague, Aimee Forand, predicted that it would take 10 years for Congress to enact medicare legislation. I am confident now that 1965 will be the year of medicare.

According to a survey made early this year by Louis Harris, the American public rates the problem of medicare as the Nation's No. 1 domestic issue. This is readily understandable—the number of persons living on a small fixed retirement income continues to increase as do their needs for health care and the prices they must pay for such care. The average cost of 1 day of hospital care has risen from \$9 to nearly \$40 since 1946. This is compounded by the fact that every year, one out of six persons over age 65 is hospitalized and, on the average, the aged hospital patient spends three times as long in the hospital as does a younger person.

About 1 out of every 10 Americans over the age of 65 lives in New York State. Also, about every 10th citizen of our State is a senior citizen.

Let us look for a moment at the financial situation of our senior citizens. In both New York City and in the State of New York as a whole, more than one-fifth of the families with an aged head had less than \$2,000 a year in income at the time of the last decennial census. The situation among the unmarried aged was worse. About 45 percent had an income of less than \$1,000 a year. These figures include social security benefits, which at the present time are received by 770 persons out of every 1,000 persons aged 65 or over in our State. These statistics, we must bear in mind, are for one of the country's richest States.

Until it became abundantly clear with this session of Congress that some form of medicare bill might be enacted, foes of medicare insisted that private health insurance and the Kerr-Mills program made it unnecessary. These claims do not stand up. According to a report of a subcommittee of the Senate Special Committee on Aging, which held hearings on the subject of private health insurance for older persons, only about half of the aged had hospital insurance and among these, only one in four had insurance that was adequate according to the definition of adequacy of the American Hospital Association. The report maintained that Blue Cross plans generally have come closest to offering adequate hospital insurance but under the pressure of competition, they, too, have had to increase premiums or decrease benefits.

The fact that private health insurance cannot offer the aged adequate protection at reasonable prices has been amply demonstrated in New York.

Last year, the New York Blue Cross plan, the Associated Hospital Service of New York, on the ground that it was paying out monthly \$5 million more than its income, asked the New York State Insurance Department for permission to

increase premiums for all subscribers. It also requested permission to adopt a form of experience rating. Under experience rating, premiums are based on the frequency with which a person or a group is hospitalized so that rates for younger persons are lower than for older persons rather than all persons or groups paying the same premium regardless of whether they are low risks or high risks. The Associated Hospital Service of New York was granted an increase, effective as of July 1, 1964, that averaged about 32 percent, rather than the 40 percent it had sought. It was denied its request to adopt experience rating which, according to New York State Senator George Metcalf, might have increased premium charges to the elderly as much as 100 percent within 3 years.

The New York 65 Health Insurance Association, made up of private insurance companies which have been permitted to act in concert in order to offer the elderly more protection at lower rates, was granted permission to raise its rates 21 percent, effective as of February 1965. A spokesman for the association said that between October 1962 and December 1963 it had run up a deficit of \$2 million and without the increase its accumulated deficit by the end of 1965 would total over \$5 million. It is interesting to note that the spokesman said the program was never intended to be the insurance industry's answer to proposals to put medical care for the aged under social security. He called it rather "another way" of providing health insurance for the aged.

Even Governor Rockefeller, at the New York State Conference on Aging in 1962, said:

I reluctantly came to the conclusion that it would not be possible to assure medical care for all the aged through the private insurance route, even though it could give protection for a substantial percentage of senior citizens with the financial means. And, at the same time, our studies of the possibility of a State plan, providing catastrophic health insurance for all citizens, also made clear that the costs of such a plan would be so high, in terms of payroll tax, as to place New York at a very serious competitive disadvantage with other States in the business and industrial field.

Therefore, I reluctantly concluded that this was one field in which we would have to look to the Federal Government to act on a national basis.

The Kerr-Mills program also is totally inadequate to meet a need that requires a national and uniform approach. The program is in its fifth year of operation; yet it has not been adopted by all the States. Because each State sets up its own eligibility requirements and benefit package, Federal money is not used equitably for persons in like circumstances and persons are penalized merely because they happen to live in a particular State of the Union. Moreover, applicants for aid, and sometimes even their relatives, must submit to a humiliating means test.

The eldercare bill that is advertised on the commercials of the American Medical Association is little more than an extension of the Kerr-Mills program.

It has most of the defects of Kerr-Mills as an answer to a national problem, to which it adds some of its own. The intent of eldercare is to encourage States to provide medical aid to the aged in the form of private insurance protection by increasing Federal matching by 5 percent over the present Kerr-Mills levels for aid furnished this way. Coverage would be open to all persons 65 years of age or over who are not recipients of old-age assistance but those with incomes above a State-set level would be required to pay part or all of the premium cost, depending upon the degree to which their income exceeds the level set by the State. A serious defect of eldercare is that, on the one hand, the income limit set by the State for its payment of premium can be so low that no new beneficiaries would be added to the rolls; at the same time, the bill neither sets a limit on premium rates that private insurance may charge nor does it establish minimum benefits. Therefore, the extra Federal matching might benefit the profits of the insurance companies more than the health of the aged. Under eldercare actual benefits would be determined by the States. If they have not been able to afford them under the present Kerr-Mills program, how will they be able to finance an expanded program?

H.R. 6675 presently before the House provides for two coordinated health insurance plans for persons 65 years of age or over—a basic hospital insurance program and a related supplementary voluntary health insurance program.

The basic health insurance program would provide persons 65 years of age or over who are eligible for social security or railroad retirement benefits with benefits similar to those contained in the King-Anderson bill, namely inpatient hospital care, posthospital extended care, home health services, and outpatient hospital diagnostic services. The bill, however, does not cover the services of radiologists, and three other specialists that, under certain circumstances, would have been covered under King-Anderson. Benefits would be financed by a compulsory payroll tax imposed on employers, employees, and the self-employed who are subject to the social security tax or the railroad retirement tax and the proceeds would be placed in a separate trust fund. Persons who are not eligible for social security or railroad retirement payments but who reach 65 within the next few years also would be eligible for benefits, which would be financed from general revenues.

The voluntary program is intended to supplement the benefits offered in the basic program. After an annual deductible of \$50, the insurance would pay 80 percent of a variety of medical costs, including payment for physician and surgeon services regardless of where rendered, electrocardiograms, basal metabolism readings, and the rental of iron lungs and oxygen tents. Persons who enroll in the program would pay a monthly premium of \$3, which would be matched from the general revenues of the Federal Government. In order to keep collection costs to a minimum, par-

ticipants who receive social security or railroad retirement benefits would have their premiums deducted from these benefit checks.

Unfortunately, the bill calls for the repeal of the medical and drug deduction now extended persons 65 or older by the Federal income tax law.

I have long urged that medical and dental expenses should be completely deductible for all taxpayers and have introduced H.R. 4656 to accomplish this.

The bill would permit taxpayers who itemize their deductions to deduct half of the cost of their health insurance premiums up to \$250, regardless of the 3-percent floor on medical deductions. This provision would apply to all taxpayers of all ages.

Mr. Chairman, the combined coverage of these two plans will provide protection of a type that few older people can now afford. If a person does not choose to participate in the voluntary program, he still would have hospitalization costs covered. I would think, however, that most aged persons would participate in the voluntary insurance plan. The increase in cash social security benefit payment provided in the bill will cover the monthly premium cost.

Mr. Chairman, the citizens of this country have been most patient, while Congress has discussed health insurance for the aged. It is time for affirmative action.

In addition to the health insurance plans, the bill before us provides for the first general benefit increase since 1958. The bill provides a 7-percent, across-the-board benefit increase effective retroactively beginning January 1, 1965, with a minimum increase of \$4 for retired workers at age 65. The committee states:

These increases will be made for the 20 million social security beneficiaries now on the rolls.

This increase is greatly needed. Since 1958 per capita disposable personal income—the spending money after taxes—has increased from \$1,825 to \$2,000, an increase of 20 percent. The cost of living has increased about 8 percent.

The increase of 7 percent is really a modest proposal. An increase of at least 10 percent would still give our older citizens only half as much as the average increase for the rest of the population. I realize, however, that the social security system must be kept actuarially sound. The 7-percent increase is a welcome updating of a system upon which so many Americans depend.

The bill before us makes other changes in our social security system which are urgently needed. I am most pleased that it includes a provision to continue to pay a child's insurance benefit until the child reaches age 22, provided the child is attending public or accredited schools, including a vocational school or a college, as a full-time student. I have long urged the adoption of such an amendment and introduced H.R. 3732 to accomplish this result.

The committee rightly points out in its report:

A child over age 18 who is attending school full time is dependent just as a child under 18 or a disabled older child is dependent, and

that it is not realistic to stop such a child's benefit at age 18. A child who cannot look to a father for support—

Because the father has died, is disabled, or is retired—

is at a disadvantage in completing his education as compared with the child who can look to his father for support.

The amendment for schoolchildren should receive our wholehearted support.

Another amendment liberalizing widows benefits also seeks to increase aid to the disadvantaged. Under this amendment widows will receive an option of receiving benefits beginning at age 60. The benefits payable to those who claim them before age 62 will be actuarially reduced to take account of the longer period over which they will be paid. Under present law, full widow's benefits are payable at age 62. The committee estimates that 185,000 widows will be able to receive benefits immediately under this provision.

Another needed change is the liberalization of the outside earning provision. Under existing law the first \$1,200 a year in earnings is wholly exempted, and there is a \$1 reduction in benefits for each \$2 of earnings up to \$1,700 and \$1 for \$1 above that amount. This bill increases the \$1 for \$2 "band," as it is called. It will apply between \$1,200 and \$2,400, with \$1 for \$1 reductions above \$2,400. In the 88th Congress I introduced H.R. 1967 and in the 89th Congress I introduced H.R. 3735 both of which increased the amount of outside earning a social security recipient could receive without a reduction in benefits. In this Congress my bill increases that amount to \$3,600. The bill before us today obviously falls far short of that goal. However, it is a step in the right direction and deserves our support.

I have long advocated legislation to provide that tips received by an employee in the course of his employment may be included as part of his wages of the purpose of old-age, survivors, and disability insurance. I have urged the adoption of such a proposal since my election to Congress. My bill this year is H.R. 4183. There are millions of employees who earn a substantial percent of their income from tips.

Under the present law they are not permitted to pay into the social security system. This presents a particular hardship as these employees are by in large earning less than many other Americans. Therefore, they and their dependents, are hit hardest by old age and disability. The bill before you seeks to correct this gross injustice. The employer will be required to withhold social security taxes on tips reported to him within 10 days after the end of the month in which they were received. The employer would pay over his own and the employee's share of the tax on these tips and would include them with his regular reports of wages. If the employee does not report his tips to his employer within 10 days after the end of the month involved, the employer would have no liability. In such a case the employee alone would be liable for the amount of both the employee and employer tax.

Mr. Chairman, another important feature of the bill is its provision to make it easier for a substantial number of our older citizens who have not had the opportunity to be covered under social security to receive coverage. The present law requires a minimum of six quarters of coverage for insured status. As a result, although the general requirement for insured status is one quarter of coverage for each year elapsing after 1950 and up to retirement age, people who reached retirement age in 1956 or earlier must have more than one quarter for each year that elapsed after 1950 to qualify for benefits. This bill eliminates this injustice.

The bill provides that the minimum would be three quarters of coverage rather than six, and therefore people who reached retirement age in 1954, 1955, or 1956 can qualify for benefits if they had one quarter of coverage for each year that elapsed after 1950 and up to retirement age. People who reached retirement age prior to 1954 can qualify if they had three quarters of coverage instead of six. The committee estimates that 355,000 people will immediately become eligible for social security payments under this provision.

Mr. Chairman, I have outlined the highlights of the amendments in H.R. 6675 which liberalize our present social security laws. These provisions combined with the health insurance plans make this a truly important piece of legislation—a milestone in the field of social insurance.

I urge my colleagues to send H.R. 6675 to the other body with an overwhelming vote.

Mr. MILLS. Mr. Chairman, I yield such time as he may require to the gentleman from Michigan [Mr. FARNUM].

(Mr. FARNUM asked and was given permission to revise and extend his remarks.)

Mr. FARNUM. Mr. Chairman, I rise in support of H.R. 6675 and wish to take this opportunity to commend the gentleman from Arkansas, Chairman WILBUR MILLS, and the other members of the Ways and Means Committee who worked long, hard hours in producing this fine piece of legislation.

No amount of oratory will keep our older citizens from getting sick, or will put money in the savings accounts of retired persons who have exhausted their savings and cannot find jobs. I am grateful, therefore, to have the privilege to vote in this Chamber today for a measure which will not only insure adequate medical care for our older citizens and retirees, but will also give a long-overdue increase in social security benefits to them.

Today, ample proof has been presented that we have the opportunity, the means, and also the will to aid in one stroke the ailing aged, students, widows, crippled children, and others worthy of our serious concern.

Let us give overwhelming evidence of this concern. Let us do what is right because it is right.

Mr. MILLS. Mr. Chairman, I yield such time as he may require to the gentleman from West Virginia [Mr. KEE].

Mr. KEE. Mr. Chairman, I rise on the floor of the House to pay tribute to Chairman WILBUR MILLS of the Ways and Means Committee. It is because of his able leadership, his wisdom and his judgment that we in the U.S. House of Representatives will this afternoon pass this overdue and absolutely essential legislation.

In conclusion, I should like to say that every American citizen, those of us here today, our older folks and our children and our grandchildren and the generations yet to come all owe Chairman MILLS a debt of deepest gratitude, a debt for which we will not be able to adequately express our appreciation. Because of his leadership and because Congress is going to enact this legislation, America is going to continue to move forward.

Thank you, Mr. Chairman—I salute you, sir.

Mr. MILLS. Mr. Chairman, I yield 3 minutes to the gentleman from New Jersey [Mr. MINISH].

Mr. MINISH. Mr. Chairman, it seems particularly appropriate that the year 1965 should see the enactment of legislation which is so important right now to people who were born at the turn of the century, or earlier, and have now achieved their 65th birthday. In their lifetime they have participated in the tremendous changes in our way of life which have occurred during this period. They found themselves, in their thirties in the midst of the greatest depression this country has ever known. In their forties they weathered the greatest war this country has ever known. In their fifties they continued to build the mightiest economy this country has ever known. It is altogether fitting and proper that, in 1965, they are rewarded with the greatest social security bill this country has ever known.

If ever any legislation had a clear mandate from the people, the proposal to provide medical care for the aged is that legislation. It was clearly pressed as an issue in the election of 1964, and the results are in. But, as President Johnson has said, there has been an increasing awareness since World War II of the fact "that the full value of social security would not be realized unless provision were made to deal with the problems of the costs of illnesses among our older citizens." The facts showed that four out of five persons 65 or older have a disability or chronic disease and that people over 65 go to the hospital more frequently and stay twice as long as younger people. The facts showed that health costs for older men and women are twice as high as for the younger age groups and that almost half of the elderly have no health insurance at all because they cannot afford it.

Another poll, in early March of this year, spoke again for the American people. The Harris poll of March 8, 1965, showed that 62 percent of Americans prefer the social security method for meeting these health costs over the last-ditch proposal of the American Medical Association, in spite of the expensive ads and mountains of "give-away" pamphlets on their so-called eldercare plan. For the people knew that, just as

the Kerr-Mills program has been found inadequate because it depends upon State matching money and a means test, eldercare would be subject to the same limitations in spite of the broad claims made for it. As the 47-year-old wife of a janitor in Buffalo told the pollster, "It would be easier if everybody shared the load for medical care when people get old." And a 39-year-old farmer in Utah spoke for his generation when he said, "Now it seems like those who need the most get the least. When you're older and need the help is when you need the money. We all will face that problem one day."

Mr. Chairman, the Committee on Ways and Means, after due deliberation, has come up with a great bill. It is a bill which provides three new programs for health insurance and medical care for the aged under the Social Security Act by establishing, first, a basic hospital insurance plan providing protection against the costs of hospital and related care—including home health visits and post-hospital care in a skilled nursing home, as well as diagnostic services; second, a voluntary "supplementary" plan providing physicians' and other medical and health services financed through monthly premiums of \$3 equally matched by Federal funds; and third, an expanded Kerr-Mills medical care program for the needy and medically needy which would combine all existing medical programs for this group into a single new title with generous Federal matching money.

I am glad to see that this omnibus bill also goes further to modernize and bring up to date our existing social security and public assistance programs as well. The 7-percent increase in cash benefits will not only recognize the changes which have occurred in our economy since 1958, when the last across-the-board increase was passed, but will also help to finance the cost of the new voluntary supplementary insurance plan. Indeed, one feature of the bill is to allow an automatic \$3-a-month deduction from the social security benefit if the individual chooses such coverage. Other features of the bill which are especially important, in my mind, are the continuation of benefits for children attending school beyond age 18 and up to age 22, as well as the liberalization of the earnings limitation. All of these changes are important.

But I am particularly glad to have the opportunity to vote in favor of the new health insurance programs contained in this bill. This is, indeed, landmark legislation. This is a vote I shall brag about to my grandchildren and, hopefully, to my great-grandchildren. For, as the President has said, "Compassion and reason dictate that this logical extension of our proven social security system will supply the prudent, feasible, and dignified way to free the aged from the fear of financial hardship in the event of illness." The needy is national, the people have spoken, and we are at long last ready to vote this proposal into law.

Mr. MILLS. Mr. Chairman, I yield such time as he may consume to the

gentleman from Wyoming [Mr. RONCALIO].

Mr. RONCALIO. Mr. Chairman, I deem it one of the great honors of my life to rise in support of the able and great chairman of the Ways and Means Committee, the gentleman from Arkansas [Mr. MILLS], and to support this legislation. My vote comes 25 years after my first associations on Capitol Hill, which began as an employee of the Senate, when I first heard what were the beginnings—in 1941—of years and years of debate, deliberation, and of hearings on this vital subject.

(Mr. RONCALIO asked and was given permission to revise and extend his remarks.)

Mr. RONCALIO. Mr. Chairman, today the Congress of the United States, in keeping with the highest and best principles of American democracy, will enact a piece of legislation that promises to fulfill the long-cherished dream of America's elderly citizens and answer the monumental mandate of her voters.

House bill H.R. 6675 is a carefully constructed and a thoroughly representative compromise, geared to give the American people a program of health and hospital care for the aged that meets what is now acknowledged as a just and worthy need.

Public concern over the problems faced by our elderly citizens is not new. Legislation to remedy their hardships is not new. The halls of Congress have resounded with debate over this issue for over 30 years. That is long enough.

Never before was the issue so dramatically focused than in the 1964 election when the American people were offered a choice—and that choice included the solution to the crises faced by the elderly in obtaining medical and hospital care.

The verdict was unmistakable. The people want a program that could best supply these services under a sound system that implements Government participation with private supplementary programs.

The bill presented today incorporates features of many proposed programs, truly representing the thinking of many conscientious leaders of both parties who recognize the moral and practical considerations that made this bill necessary.

By choosing to meet this moral obligation through the social security system, lawmakers have again exposed themselves to the critics of social progress who would have the American people renounce their obligations in a spirit of negative defeatism over what were once considered the insurmountable challenges of cruel circumstance.

A NEW SPIRIT

Today a new spirit leads this land, a spirit that fires hope in the hearts of those who would otherwise reconcile themselves to the forces of misfortune they could not control.

Today the American people have set forth on a road that will not be barred by these forces, and in following this path they are again harassed by those who would resign man to the mercies of his environment.

Their arguments, not unfamiliar to those that rocked these halls when Presi-

dent Roosevelt proposed social security, ring as hollow now as they did then. What was questioned then has been answered, but the answer has fallen on deaf ears.

The social security system is sound. It has fulfilled the promise it held forth in those dark days, and it will continue to fulfill them. These amendments, administered through the reliable social security system and a supplementary voluntary private plan, will equally confound critics with undeniable success.

The health care bill we are voting on today incorporates the best features of several measures considered by the Committee, including the basic plan for hospital, diagnostic, and posthospital health services for all persons over age 65, administered through the social security system as provided in the original King-Anderson bill. H.R. 6675 provides a voluntary supplementary plan covering physicians and surgical fees including radiology and pathology charges and related services, to be administered by private insurance carriers, as suggested in the AMA-sponsored "eldericare" and the Republican minority bill, sponsored by JOHN W. BYRNES, of Wisconsin.

In addition, H.R. 6675 increases social security benefits by 7 percent and makes a number of other changes in the Kerr-Mills law and in the Social Security Act. The measure has been carefully designed to safeguard the actuarial soundness of the social security system and to protect the independence and integrity of the professions. Without this assurance for the doctors and their colleagues in medicine, I would not support this bill.

The poet Browning said:

Grow old along with me!
The best of life is yet to be,
The last of life, for which the first was made.

The part of the 89th Congress in the realization of this poetic dream is indeed "our finest hour."

Because the people of Wyoming and elsewhere will be confronted with the question of "how does this legislation affect me?"—I ask unanimous consent to include at this point in the RECORD a brief summary of the major provisions of H.R. 6675, consisting of three tables, and containing pertinent information on each major part of this important bill.

The analysis is as follows:

SUMMARY ANALYSIS OF MAJOR PROVISIONS OF H.R. 6675: MEDICARE AND SOCIAL SECURITY AMENDMENTS OF 1965

(House version—Apr. 1965)

This analysis of the Medicare and Social Security Amendments of 1965 (H.R. 6675), as acted on by the House is in three parts: (1) a description of the basic hospitalization program; (2) a description of the optional supplementary medical program; and (3) a description of amendments to the Social Security Act, the Kerr-Mills law, and other miscellaneous provisions.

PART 1—BASIC HOSPITALIZATION PROGRAM (UNDER SOCIAL SECURITY SYSTEM)

Eligibility

All persons aged 65 years or over who are now, or will in the future, be entitled to monthly social security or railroad retirement benefits (except Federal employees who retired after 1959).

All persons aged 65 years or over, or who will reach age 65 before 1968, who are not

eligible for monthly social security or railroad retirement benefits. This part of the program to be paid for from general revenues of the Federal Government, not paid for out of social security trust funds.

Effective date

July 1, 1966 (except for services in extended care facilities, which will be effective Jan. 1, 1967).

Enrollment

No enrollment necessary. Coverage is automatic to those eligible.

Cost to the individual

Benefits extended to eligible persons without cost as a matter of right; no "needs test" required.

Benefits

(1) Inpatient hospital charges for up to 60 days of hospitalization in each spell of illness, subject to a \$40 deductible amount.

(2) Twenty days of nursing home care in each spell of illness, after transfer from hospital; 2 additional days of nursing home care (if needed) can be added for each day that the patient's hospital stay was less than 60 days, to a maximum total of 100 days.

(3) Outpatient hospital diagnostic services, subject to a \$20 deductible amount for such services furnished by the same hospital during a 20-day period.

(4) Posthospital home health services for up to 100 visits after discharge from hospital or nursing home (when patient is under care of physician).

Financing

Through the social security system—payroll taxes from employee, employer, and by self-employed persons. Taxes paid into separate hospital insurance trust fund to assure that actuarial soundness of trust funds and the entire social security system is safeguarded. Tax rates for employee (matched by employer) will be: 1966, 0.35 percent; 1967-72, 0.50 percent; 1973-75, 0.55 percent; 1976-79, 0.60 percent; 1980-86, 0.70 percent; 1987 on, 0.80 percent.

These amounts would be automatically deducted from payroll check (as at present) on first \$5,600 earnings a year during 1966-70 period. Thereafter, they would be based on first \$6,600 of annual earnings. Program will cost each employee, employer only 38 cents a week, rising to about 54 cents a week for each during 1967-72 period.

PART 2—OPTIONAL SUPPLEMENTARY MEDICAL PROGRAM (UNDER PRIVATE INSURANCE CARRIERS)

Eligibility

All persons age 65 or over, on an optional, voluntary basis, regardless of whether or not they are eligible for social security, railroad retirement, or other benefits.

Effective date

July 1, 1966.

Enrollment

Enrollment for persons age 65 years or over before January 1, 1966, will begin 2 months after enactment of bill and continue to March 31, 1966. Regular enrolling periods thereafter.

Cost to the individual

If a person chooses to participate in this program, it will cost him \$3 per month. Amount would be automatically deducted from monthly benefit check of those persons receiving social security or railroad retirement benefits. Others would pay their contribution into special trust fund directly.

Benefits

In addition to the benefits listed in part 1, those choosing to participate in the supplementary medical program would be entitled to:

(1) Physicians' and surgical services furnished in a hospital, clinic, office, or in the home.

(2) Hospital care for 60 days in a spell of illness in a mental hospital (180-day lifetime maximum).

(3) Home health services (without regard to hospitalization) for up to 100 visits during each calendar year.

(4) Additional medical and health services, provided in or out of a medical institution, including: diagnostic X-ray and laboratory tests, electrocardiograms, basal metabolism readings, and other diagnostic tests; X-ray, radium, and radioactive isotope therapy; ambulance services (under limited conditions); surgical dressings, splints, casts, iron lungs, oxygen tents, artificial limbs, eyes, etc.

Benefits under this program are subject to an annual deductible amount of \$50. Then the program will pay 80 percent of the patient's bills (above the \$50 deductible).

Financing

Persons participating in this program will pay \$3 a month (\$36 a year). An additional \$3 per person, per month will be paid into fund by Federal Government out of general revenues.

PART 3—OTHER PROVISIONS

Social security benefits

Increases by 7 percent (with a minimum increase of \$4 a month) all old-age, survivors, and disability insurance benefits. Increases would be retroactive to January 1, 1965. New minimum benefit raised from \$40 to \$44 a month.

Child's insurance benefits

A child's insurance benefits would continue to be paid until the person reaches age 22 (instead of age 18) if child is attending accredited school or college as a full-time student after he reaches age 18. Will be effective as of January 1, 1965 and benefit estimated 295,000 young people.

Optional benefits for widows at age 60

Widows may have option of receiving social security benefits at age 60, with actuarial reduction of benefits they would otherwise receive at age 62. Effective for second month after enactment of bill, benefiting estimated 185,000 widows.

Disability insurance amendments

Liberalizes eligibility requirements and waiting period for persons covered by disability insurance provisions of Social Security Act. Will benefit estimated 155,000 disabled workers.

Benefits to persons at age 72 or over

Liberalizes eligibility requirements by providing a basic benefit of \$35 a month at age 72 or over to certain persons with a minimum of three quarters of coverage under the Social Security Act, acquired at any time since the beginning of the program in 1937. Will benefit an estimated 355,000 persons.

Retirement test

Liberalizes the social security earned income limitation. Beginning in the 1966 tax year, a person receiving benefits will be able to earn \$1,200 a year without having his benefits reduced; earnings between \$1,200 and \$2,400 a year would be subject to a \$1 reduction in benefits for each \$2 of earnings up to \$2,400; a \$1 reduction in benefits for each \$1 of earnings above \$2,400 would take place. Existing law limits this provision to \$1,700 instead of \$2,400.

Miscellaneous amendments

Other amendments to the Social Security Act authorize benefits to certain divorced women, coverage of self-employed physicians and interns, amendments affecting annual gross earnings of farmers, coverage of cash tips received by an employee after 1965, and an exemption from social security taxes of self-employed persons of the Amish and other religious sects.

Improvement of Kerr-Mills program

Extends the provisions of expanded State medical assistance programs not only to the indigent aged, but also to needy persons who are part of the dependent children, blind, and permanently and totally disabled programs. Establishes a single and separate medical care program to replace the differing provisions for the needy in other parts of the Social Security Act. Provides a level of medical services States must offer to receive Federal payments. Requires States to provide a flexible income test for eligibility.

Public assistance amendments

Increases the Federal share of payments under all State public assistance programs, effective January 1, 1966. Contains other amendments providing Federal incentive to States to benefit aged persons in tubercular and mental institutions.

Child health program amendments

Increases Federal authorization for maternal and child health services and for crippled children services. Authorizes grants to higher education institutions to train professional personnel for health and related care of crippled children, particularly mentally retarded children with multiple handicaps. Authorizes a new 5-year program of special project grants to provide health care and services for children from needy areas. Authorizes grants to help States to implement mental retardation plans.

Financing improved social security benefits

Improvements in the regular social security program and increased benefits provided in the bill would be financed through a revised payroll tax schedule. Taxes on employees, employers and self-employed persons are paid into social security trust fund as in the past 30 years. Rates of tax are designed to guarantee the actuarial soundness of the social security system.

The revised tax schedule and the rates under existing law are—

Years	(In percent)			
	Employee and employer tax rate (each)		Self-employed tax rate	
	Existing law	Proposed in bill	Existing law	Proposed in bill
1965.....	3.625	3.625	5.4	5.4
1966-67.....	4.125	4.0	6.2	6.0
1968.....	4.625	4.0	6.9	6.0
1969-72.....	4.625	4.4	6.9	6.6
1973 on.....	4.625	4.8	6.9	7.0

As in the past, these amounts would be automatically deducted from payroll check. Tax would be paid on first \$5,600 (instead of present \$4,800) during the 1966-70 period. Thereafter, they would be paid on first \$6,600 of annual earnings.

Mr. MILLS. Mr. Chairman, I yield such time as he may consume to the gentleman from Texas [Mr. THOMPSON].

Mr. THOMPSON of Texas. Mr. Chairman, there is one little matter I should like to clear up for the House. It has been said in years gone by that I was the swing vote on the committee keeping the medicare bill as we have had it in bygone years from passage. Of course that is sheer bunk, and we will knock it over right now.

It is true that after the Kerr-Mills bill was passed, I did say I thought we ought to try it before we tried something else. We did try it. It has become apparent that some other method must be tried. We have come up with it. It is before you now. I believe it is absolutely sound.

I voted for it in the committee and I shall vote for it on the floor.

I should like to say that I have served under quite a few committee chairmen in the years I have served in the Congress—and the years are now getting to be quite a few. There have been some who were exceptionally good. But I have never served under a chairman who showed the patience, the perseverance, the knowledge of his subject to compare with WILBUR MILLS. This bill and the program following it will be a monument to him as long as the memory of man continues. It has been a great pleasure and a privilege to work with him.

(Mr. THOMPSON of Texas asked and was given permission to revise and extend his remarks.)

Mr. MILLS. Mr. Chairman, I yield 3 minutes to the gentleman from New York [Mr. BINGHAM].

(Mr. BINGHAM asked and was given permission to revise and extend his remarks.)

Mr. BINGHAM. Mr. Chairman, this is a truly historic occasion and it is a privilege to be a Member of this body and to take part in it.

H.R. 6675 establishes two great principles:

First, it establishes the principle of extending the social security system to cover a major portion of the costs of medical care for older people; the cost of extended hospitalization. And it does this on the same basis as social security itself—on a uniform, widecoverage basis—with the benefits accruing as an earned right, not charity.

Second, this bill establishes the principle that general revenues may properly be used to help older people meet their major medical costs without any means test. General revenues under this bill will be used to pay for the hospitalization of those over 65 who are not under social security already and also, to pay the Government's share of the voluntary system for coverage of doctors' bills.

The first legislative act of my career as a Member of Congress was to agree to become a sponsor of H.R. 1, the original King-Anderson bill as it was introduced this year. This was truly an honor. This was a good bill, providing as it did for hospital and related benefits under social security and for substantial improvement in the basic social security program. Among these improvements was a provision to include tips as part of income for social security purposes—as they have been for income tax purposes—thus correcting a longstanding injustice to many of our citizens who depend on tips for their livelihood.

As H.R. 1 was considered by the Ways and Means Committee, it was improved in many respects. Most importantly, a supplementary voluntary health insurance program has been added, to be paid by equal contributions, one-half by the individual and one-half from general revenues. The \$3 monthly premium each participant will pay is less than the minimum increase in retirement benefits. Thus, no participant who elects this additional coverage will get less in

monthly cash payments when the program takes effect.

Under this voluntary program, the benefits will include payment for physicians, services in the hospital, office or home; 60 days of hospital care in a psychiatric hospital; and home health services. The senior citizen will pay the first \$50 for such services and the program pays 80 percent of costs over this amount.

Another important improvement, which had been a subject of many letters to me and which I had urged upon the Ways and Means Committee, was to extend social security benefits for young people continuing their education up to age 22. This will undoubtedly encourage many youngsters to go on to college and professional schools who would otherwise have been unable to do so.

The bill we will, I trust, adopt tomorrow is a great bill—a milestone in the march made by this country toward the realization, for all our citizens, of the full opportunities and potentialities offered by our uniquely rich and powerful economy.

Mr. MILLS. Mr. Chairman, I yield 3 minutes to the gentleman from Texas [Mr. POOL].

We proudly boast that this land of ours is the land of the free. The enactment of this bill will go a long way to make this boast come true for our older people; for the first time they will be free from destitution as a result of illness and from the fear of such destitution. They will be free, in most cases, from degrading means tests. They will be free from the miserable need to beg their children for help, their children who, in the past, may have had to choose between better education for their own children and medical care for their parents.

Last year, I must confess, I had occasion during my campaign to say some unkind things about the distinguished chairman of the Ways and Means Committee. Today I am happy to say that he has proved me wrong. With the deepest sincerity, I congratulate the chairman and the members of the Ways and Means Committee, and particularly my very able colleague, the gentleman from New York [Mr. KEOGH], on a magnificent achievement.

Mr. POOL. Mr. Chairman, I am one of the Members of Congress who introduced the so-called eldercare plan several weeks ago. I felt that it was far better for the States to handle this problem instead of the Federal Government. Since that time, the Ways and Means Committee has adopted several of the eldercare provisions. However, I feel that so long as this project is tied to social security or a payroll tax that it is still obnoxious to my philosophy of government in that the Federal Government will still control the program. I do not think that it is wise to solve this problem by political devices such as this bill. I feel that the eldercare bill will provide where possible, for individual initiative and responsibility of our people; and that the medicare bill still is a matter of Federal intervention into a purely local problem. What we are doing here today and tomorrow, if the

bill passes, is the first step in socializing our medical profession.

I hope, that Congress, in its wisdom, would see fit to not pass legislation which would allow Federal agents to go snooping around looking at medical records, talking to doctors and their patients, and destroying the doctor-patient relationship which is a very personal and privileged right of our citizens.

And then again, I think of the politics that will be involved when Washington bureaucrats get into this picture. What is going to keep utilization committees that will be set up from being political in nature keeping some patients out of certain hospitals?

And what is to keep this same political committee from moving a patient from a hospital before his treatment ends? There will be many arguments against this supposition. But we all recognize that in such a program as this, there will be a day when the money well will run dry. And then the question will arise as to who gets the benefits. Will this be based on politics and how you stand in Washington? Are we going to run to the Federal Government in Washington with all of our problems, or are we qualified at home to solve most of them?

I sincerely hope that this Congress will be realistic and pass legislation in this field that will allow Americans to keep on striving for success and will provide incentive for our young people, middle-aged people and our aged citizens. Let us not take this first step toward socialized medicine.

Mr. MILLS. Mr. Chairman, I yield 8 minutes to the gentleman from Texas [Mr. PICKLE].

(Mr. PICKLE asked and was given permission to revise and extend his remarks.)

Mr. PICKLE. Mr. Chairman, it is with great reluctance that I arise to oppose H.R. 6675 in its present form. I especially regret to do this because I believe strongly in the principles of the social security program; and I fully agree that as a state and nation we need to do more for the care of our elder citizens. And, I am not unmindful that it would be easier to simply cast my vote rather than to stand here and openly voice my objections to an administration bill, advocated by our great President and my personal friend for many, many years; and to oppose the general approach of a measure so eloquently presented to this House by one of the most knowledgeable legislators in my memory, the gentleman from Arkansas, the Honorable WILBUR MILLS.

Our Government needs to do more to improve our aid to the elderly and in many of the other broad fields which have been explained; but, Mr. Chairman, which government? Where does the real responsibility lie?

There is no question in my mind as to the need for comprehensive programs of medical care for aged Americans who are unable to pay for necessary health services. I do question, however, the approach we are asked to take through this particular measure, which largely disregards the rightful roles of the

States, and finances health care benefits to many millions of older Americans who are self-supporting, and may not need Government assistance.

In this connection, Mr. Chairman, I want to say that the State of Texas has approached the problem of medical care for the aged with understanding and foresight. Texans are justly proud of our positive, highly effective State programs that render the medicare section of H.R. 6675 unnecessary for our citizens.

The State of Texas has implemented the Kerr-Mills Act to provide hospital, medical, surgical, radiation and nursing home benefits for the needy aged. I would like to tell the House something about our program. The State purchased an insurance policy from Blue Cross for some 230,000 needy aged, representing 30 percent of the entire over-65 population in Texas. Up to 9,000 patients are being hospitalized each month through coverage provided by the program. Almost 11,000 are receiving nursing home care.

In my opinion, this Texas program is regarded as one of the finest in the Nation.

We also have cooperative-type senior citizen insurance programs sponsored by private companies—such as the Texas 65 plan which is specially tailored for the aged.

As a result of these efforts, Texas now ranks first among all States in the percentage of the aged who have one or more health insurance policies. Seventy-two percent of the elderly in Texas are covered by health insurance.

More than 250,000 elderly have been admitted to Texas hospitals since the Kerr-Mills program was placed into operation on January 1, 1962. During the first 2 years of this program's operation, the State provided needy elderly citizens with hospital and medical services totaling \$60,205,652. Here is how it works:

Under this program, each person on the old-age assistance rolls in Texas is covered by Blue Cross insurance at a premium of \$8.76 per month. This entitles the individual to \$10 per day for the first 15 days of hospitalization—plus ancillary costs—and \$6 per day thereafter.

There's no redtape or delay in processing claims.

The welfare department simply certifies that the person is a recipient of old-age assistance, and the individual is admitted to any licensed hospital on the recommendation of his physician. Less than 3 percent is spent on administration costs.

Studies last year showed that the average hospital stay per patient was approximately 9 days, with an average per day cost of some \$25. Also, physicians' services totalling \$3,682,829.51 were provided in over 177,000 cases at an average per-patient cost of \$46.67.

Another feature of this program is financial aid to old-age assistance recipients in nursing homes—over and above the old-age assistance grant. Studies during the past year showed that nearly 16,000 persons in nursing care—repre-

senting an average stay of 183.6 days and a total expenditure of \$7,807,767.75.

The eyes of the Nation have focused on Texas since it was the first State to provide health care for its needy aged on an insured basis. So, I repeat, Mr. Chairman, Texas is proud of its positive program for the aged.

I would sincerely hope that other States would act in the same responsible manner. In this way we can avert an even greater tragedy than the medicare situation with which we are faced today.

Let us give the Kerr-Mills approach to this complex program a further opportunity to prove itself—as it has done in Texas. Already this joint Federal-State program has been adopted in 40 States, the District of Columbia, and 3 territories.

If I could vote for a reasonably expanded version of the Kerr-Mills approach, I would gladly do so.

If I could vote for the 7 percent increase for social security benefits, I would certainly do so; because it is needed.

If I could vote for the provision that raises the amount that a person can earn under old-age, survivors insurance from \$1,200 to \$2,400, I would do so. I would welcome the chance to support measures that would improve this program along these and other lines. Also, I might add that the substitute has a lot to be desired.

I object to this bill primarily because of the payroll approach.

In addition, I do not think it is fair to include in the bill requirements for the restaurant owner to report tips for social security income purposes. It will be extremely difficult—if not impossible—to administer.

The same would be required of barbers, beauty parlor operators, filling station attendants, shoeshine boys, grocery clerks, or anyone who receives tips. And I think that in one provision it would certainly be fair to allow a person who has visual problems to choose whether he would go to an optometrist, as well as a physician.

I do not have a choice, however, to vote on any of these particular phases of the bill; and I recognize the rules of the House, along with the facts of life.

Mr. Chairman, let me make one other point.

I think we have the greatest medical profession in the world; and I will admit that our physicians, or hospitals, or the legislatures, have not been, in many instances, as progressive as they should have been; and I believe that they realize this. But in my State of Texas, they are trying to find the right kind of answer in this medical care field. They are taking a positive approach. We do have a good program. Some of you may think that we should go much further—and, indeed, we will; because the State of Texas this past November approved a constitutional amendment which will permit additional persons to receive medical care through vendor lien payments who are not now covered under the old-age assistance program. I am confident our legislature will establish the limit of at least \$2,000 or more; or

perhaps it will be based on need, as this may be the best approach. The main point, however, is that there should be an amount or point beyond which Government should not compete against industry. This would bring many more thousands of persons under the program. But my State is doing a good job. I regret that all States have not done enough in this field; but I am sure each State has its own individual problems. As long as my State is doing a good job, in my opinion, I want to give them a right to continue and improve their present program rather than to put on them the payroll tax provision with the inherent problems of bigness and expansion that are attendant and with a result that will greatly overburden our hospitals at this time.

I say to the House, give each State a further opportunity under the Kerr-Mills program to do its job. I am confident we will do it.

Mr. CABELL. Mr. Chairman, I thank the gentleman for yielding.

Mr. Chairman, I rise in opposition to this bill in the full knowledge that any such opposition can be misconstrued and the motive for such opposition distorted.

And it is difficult because the fundamental purpose of the bill is a noble one—the proper care for our senior citizens.

It is not the objective that I oppose; it is the means proposed to attain this objective.

I have consistently favored in the past, and will continue to favor in the future, legislation to assist any senior citizen, who needs this assistance, in obtaining medical and hospital care.

When I cite need as a criterion for such assistance, I do not imply that we should be penurious to the extent that we have been in previous measures.

I mean to include coverage to those who have a decent subsistence and who have sufficient assets to insure this subsistence—but whose assets would not weather the onslaught of a severe or lingering illness.

But this bill taxes the workingman with a low income in order to provide benefits to those who do not need such assistance.

Not only does it increase the direct payroll taxes of these people, but it will inevitably increase their cost of living because the manufacturer, the processor of foods, and the distributor must raise the price of his goods and services to compensate for his increased contribution to the social security fund.

If you were going after a hawk in the henhouse, I ask you, Would you cut loose inside the henhouse with both barrels of a scatter gun?

In order to kill the hawk of need of our senior citizens, we are wounding and crippling all the chickens in the henhouse.

Under the rule amendments are limited, which is just as well, because a bill of this magnitude cannot be written on the floor.

So I ask you to defeat not only this bill as presented but also the substitute—not because we do not want the ultimate and exemplary objective—but in order to

start from scratch and then pass out a bill that not only accomplishes our real objective but does so in a form with which we can live.

Thank you.

Mr. MILLS. Mr. Chairman, I yield 3 minutes to the gentleman from California [Mr. BURTON].

(Mr. BURTON of California asked and was given permission to revise and extend his remarks.)

Mr. BURTON of California. Mr. Chairman, I wish to commend the dean of our delegation, the gentleman from California, the Honorable CECIL KING, because the proposal pending before us today is due in significant measure to his determination and effort over the years.

I would also like to add my voice to commend the Committee on Ways and Means for its many months and years of study, and its development of this fine proposal.

I would like to express the highest praise for the distinguished and able chairman of the Committee on Ways and Means, the gentleman from Arkansas, WILBUR MILLS, who has constructed, in my view, a legislative product that is truly a marvel, a product that legislative historians will record as truly one of the great landmarks in the history of man's effort to wage war against one of his ancient enemies, the war on disease.

Those of us in California have ample reason to support this legislation which will provide to our State, that has the largest number of people over 65 of any State in the Nation, some \$308 million of medical benefits the first year—\$220 million of basic benefits, and \$88 million in supplemental benefits.

This legislation will provide also some \$28 million to our State for our crippled children, and for tubercular and mental health services.

This bill is going to put into the pockets of my fellow Californians some \$213 million its first year, \$190 million to the old-age, survivors, and disability insurance beneficiaries, and some \$23 million to our public assistance recipients.

All in all, our fair State and its people in the first year will be favored to the tune of some \$550 million, a not modest sum.

In this connection, I have some four questions I should like to pose to the chairman of our committee. These are questions which, would be helpful to our State department of social welfare, in implementing the provisions of this bill when it becomes law.

Question No. 1: Section 1902(A), paragraph 10, says:

(A) A State plan must provide equal medical assistance to individuals receiving aid under other categories; and (B) If the plan provides assistance to persons not receiving aid under other categories, the medical assistance given must be the same.

Can this be interpreted to mean that funds as provided under section 1903 would be available for a plan which in its first phase provided medical service only to recipients of assistance under other social security act titles? Subsequent phases would be concerned with additional medically indigent groups to the extent State resources permitted?

Mr. MILLS. The answer to the question is, "Yes."

Mr. BURTON of California. I have three questions with reference to those combination social security beneficiaries who concurrently receive public assistance.

If the social security beneficiaries have had deducted the \$3 amount from their old-age survivors and disability insurance check, am I correct in assuming that the State agency administering the public assistance programs should not consider that \$3 as income in determining the amount of the public assistance payment?

Mr. MILLS. The answer is, "Yes."

Mr. BURTON of California. In other words, in California, where there is a ceiling on the total amount of public assistance grants, plus other income, the \$3 should not be taken into account as other income in the determination of the amount of the public assistance grant, nor as income in determining income for purposes of determining whether the grant plus other income exceeds the State's ceiling in that regard?

Mr. MILLS. The gentleman is correct.

Mr. BURTON of California. Of course, any medical care that results from the \$3 deduction will be considered in determining how much medical care the individual needs?

Mr. MILLS. That is correct.

Mr. BURTON of California. I thank the chairman very much.

Mr. MILLS. Mr. Chairman, I yield 5 minutes to the gentleman from Illinois [Mr. GRAY].

Mr. GRAY. Mr. Chairman, it is a great privilege today to rise in support of the committee bill, a bill when enacted into law, will be a milestone in our history of progress in our beloved country.

The late beloved President Kennedy said that although we have the strongest and richest country on the face of the earth, there are 35 million people living just on the outskirts of hope. I know this bill will bring great hope to the elderly people who need medical care and are now living and dying on the outskirts of proper medical care hope.

My heart is heavy as I rise today, because of the campaign being waged by the American Medical Association against this bill. All throughout my districts there are billboards saying, "Vote for eldercare, because medicare is no good." They have spent large sums of money for TV, radio, and newspaper ads in trying to discredit the committee bill and sell support for the eldercare bill.

I have this one telegram that is evidence of the type of bitter campaign they have waged against this bill.

I am bitterly opposed to the outrage being forced on us in the guise of medicare. You know this is against the future of the people who support you. It is a vote getter with future results destined to pull the American taxpayers further into financial slavery by the hands of Congress.

This is the kind of brainwashing being perpetrated upon the American people by the American Medical Association. As we come to the close of debate on this

historic bill, I would like to put this argument in proper perspective.

The American Medical Association in opposing this bill has advanced three major arguments. First of all, they say that eldercare will give more benefits to more people at less cost. I once saw an automobile dealer in my district who advertised that he was selling automobiles below cost. I said, "How can you sell cars below cost and still stay in business?" He said, "I could not do it if I did not have a volume business." They argue that under eldercare we are going to get more benefits for more people at less cost—and you know it is not so.

The second argument they have been advancing is that the committee bill will soak the young people for the benefit of the old. When you buy an insurance policy at age 21, you do not expect to die the next day. You pay the premiums over a long period of time so that when you do pass on, your loved ones will have some kind of income. That is all that this committee bill does. It allows young people to pay in a small amount monthly on their social security taxes so that when they reach 65 years of age, they will have a good medical care program for themselves without marching in and signing a pauper's oath to get help as is now required by law in many States including Illinois.

Third, the argument advanced by the American Medical Association is that the social security approach will lead to socialized medicine. This is the same argument that was advanced on the floor of this House of Representatives in the 1930's against the Social Security Act. Yet, there has not been one person to drop in a bill to repeal the social security law. This would be a disaster. I say to you that after this bill becomes law, there will not be one bill dropped in the hopper to repeal this important program. This great bill that we are soon going to vote on is similar to the social security program in respect to the manner of collecting and spending from a trust fund. It will be financially sound and will not jeopardize the present social security payments.

All we do in this committee bill is to take some funds from the general revenue fund and to have the individual pay in at the local level and some funds from a payroll tax. This is spreading the cost evenly and giving the benefits evenly.

The eldercare bill would not provide the benefits that people need in many States. You could have a relative living in one State who needs medical care and another relative living in another State in need of medical care. If a rich State should participate in the program and a poor State did not, one relative would get benefits and the other relative would not. This bill provides even benefits fairly to all throughout the United States.

I once knew a man who built a wall.
A wall unfriendly, grim and tall.
I knew this man couldn't be bad.
Maybe timid or even sad.
So I built a tower by this wall so grim
And looked down and smiled on him.
This noble man's heart was about to break,
So he tore down the wall and built a gate.

This argument of eldercare versus medical care is just that simple. On one side of the wall you have the so-called voluntary plan called eldercare that you can climb if you are tall enough and if the State wants to help pull you over, and the committee bill provides a gate with which all can enter with dignity and hope.

Yes, there were those who opposed the social security plan 30 years ago who now drive their big automobiles down to the postoffice and get that monthly check and then endorse the check with a gold-plated fountain pen and then cash it. They think it is a wonderful program. They will do the same thing under this program of medical care after this Congress passes it and it becomes law.

Let us vote down this substitute and let us pass this bill. Let us open up the gates for a decent and honest medical program for our elder citizens. Let us build a healthier and happier America by supporting the bill that has been reported to you by your committee after years of study.

The committee bill provides medical care to all age 65 and over beginning in 1966. It allows a 7-percent increase across the board to all now drawing social security effective January 1 of this year, it provides more money to the States for needy welfare programs such as aid to the blind, children of unemployed fathers, and so forth, and many other worthwhile benefits, and yet it provides for insurance for those who want coverage to pay doctor's bills with no strings attached, any doctor of your choice. In closing, this bill will help everybody. Thank you very much.

Mr. MILLS. Mr. Chairman, I yield 8 minutes to the gentleman from Missouri [Mr. JONES].

(Mr. JONES of Missouri asked and was given permission to revise and extend his remarks.)

Mr. JONES of Missouri. Mr. Chairman, first I want to join the many other Members who have paid their respects to the chairman of this great committee, a man in whom we have had confidence for many years and a man who has rendered invaluable service to this Nation.

I have followed his leadership in this field for a long time and it is with some difficulty and regret that I say that I cannot go all the way with him. I can appreciate the very great difficulty he has been under. I think I recognize the great pressure that is upon him.

I believe he has tried his best to bring out a bill to give the services needed and the same time maintain as much responsibility as possible.

My apprehension today with respect to this bill is based on the belief that we are going too far too fast, creating obligations in excess of our ability and our capacity to fulfill.

The estimates which I have received indicate that with the implementation of this legislation in July 1966, we will be faced with a shortage of some 250,000 hospital beds. In other words, we will create an obligation to furnish hospitalization and medical services to people, but there will not be available the physi-

cal facilities, not to mention the professional and technical services necessary to render the service we wish to make available, and which is promised under this bill.

If we tried to provide such hospital facilities by 1966, it would be an impossible task, not to mention the fact that it would involve an investment of some \$6.5 billion, much of which would have to be added to the cost of this program.

I believe it has been pointed out during this debate many times that through the fantastic advances we have made in medical technology, we have today the best medical care program of any nation, as attested by the ever-increasing life span of our people. To make the modern techniques and facilities available to all, we passed the Kerr-Mills bill a few years ago. While it has not been fully implemented in all States, it does provide an opportunity of health care to every person who otherwise would be unable to receive such care.

The Kerr-Mills program is a good program and, so far as I have observed, the areas in which it is inadequate and in which it can be improved we have an opportunity to amend. I am happy to say that this bill today would make improvements in that law.

Also, through the Hill-Burton Act and other programs too numerous to mention, we can increase the physical facilities needed to provide adequate care for all who need it.

But we cannot get that done by the time this bill would go into effect. Our problem today—and I agree there is a problem which needs to be met—is one of a shortage of facilities and a lack of competition, brought on to a large degree by the medical profession itself, which in my opinion has not used the influence it has in encouraging the education and training of more doctors.

When we provide the facilities the cost will be reduced. On the other hand, if we continue to increase the load without increasing the facilities, we will encourage more inflation. There will be, I believe, an increase in hospital costs. There will be an increase in medical fees to the doctors.

Only this month I received a statement from a doctor with whom our family does business in the Washington area. He said that effective May 1, an office call will be increased from \$7 to \$8. That is typical of what is going on and one of the things about which I am apprehensive in this bill.

I read the tables in the report. I note that by 1990—someone will say, "that is 25 years from now, and we do not have to worry about that"—the cost of the basic health program alone will rise to \$9 billion annually, and that does not take into account the cost of other programs we are including in this bill.

Through the many programs that we have before the Congress today—I believe it is safe to predict most of which will be passed—we are providing increases in income, improvements in living conditions, the building of more homes, the providing of more education, and increases in the ability of all of our

citizens to provide not only the essentials but many of the luxuries. I believe we have failed to take into consideration the overall picture and the costs that we will face.

Within the next few weeks our great chairman here will be before this House asking for the approval of a new debt ceiling. I think it is inevitable. The budget for 1966 calls for deficit spending. I do not agree that we are considering any \$100 billion budget this year. I think it is closer to \$121 billion, and I think that deficit will be reflected when we are called upon to approve a new debt ceiling. In addition, we are being asked to reduce taxes. Now, I want to know where we are going to get the money to pay for this. I want to ask the chairman when he thinks we are going to have the nerve, the courage, to assess enough taxes to pay for these programs that we are getting. When are we going to do it, Mr. Chairman?

Mr. MILLS. Mr. Chairman, will the gentleman yield to me?

Mr. JONES of Missouri. I will be happy to yield to the chairman.

Mr. MILLS. The gentleman asked me to advise him when we will levy enough taxes to take care of these programs?

Mr. JONES of Missouri. Yes.

Mr. MILLS. Let me call the gentleman's attention to just what this bill does do in that respect. As I pointed out yesterday, although there may be, as has been stated, approximately \$6 billion in benefits to be paid out, that is divided in this way: \$4.2 billion of it would come from the trust funds. The remaining \$1.366 billion would come from the general funds of the Treasury. Now, let me point out here to the gentleman, since we are comparing proposals, that all under both bills \$1.9 billion would come from the trust funds. So taxes are levied both in Mr. BYRNES' proposal and in the committee proposal to take care of these items in the OASDI system.

Mr. JONES of Missouri. Where are you levying these taxes?

Mr. MILLS. Oh, I can assure you that this hospital trust fund and this social security trust fund, the OASDI fund, are actuarially sound based upon increased tax rates which go into effect on January 1, 1966, and from then on at future dates.

The CHAIRMAN. The time of the gentleman has expired.

Mr. MILLS. Mr. Chairman, I yield the gentleman 4 additional minutes.

Now, we have done what the gentleman claims that we have not done historically with respect to the general fund of the Treasury. We have maintained these expenditures on an actuarially sound basis supported by payroll taxes that has prevented the general fund of the Treasury putting out any money. That is what I would think any conservative-minded person would have us do, and I know that my friend appreciates the fact that we have done it.

Mr. JONES of Missouri. Would the gentleman tell me this: Am I correct here? As I read this bill, the increase in the withholding tax is going to be thirty-five one hundredths or, in other

words, about one-third of 1 percent. That is the increase in the tax.

Mr. MILLS. That is for the hospitalization program.

Mr. JONES of Missouri. For the hospitalization.

Mr. MILLS. That is right.

Mr. JONES of Missouri. That means for the person with an income of \$5,600 that he is going to pay in about \$18.40 a year.

Mr. MILLS. It is \$19.20, I believe, but I would not quarrel with the gentleman on that.

Mr. JONES of Missouri. It is in that neighborhood. Maybe my arithmetic is wrong.

Mr. MILLS. Yes.

Mr. JONES of Missouri. But I cannot conceive that that is going to provide enough money to pay for the hospital care when you figure that the cost of an insurance policy to pay for that same type of program runs up to about \$360 a year.

Mr. MILLS. If my friend from Missouri will yield, I am not an actuary. I cannot tell you that I know it will. All I can tell you is that we have proceeded in this instance on the basis of taking the actuary's high-cost estimates for the purposes of determining what this program will cost us. The gentleman from Wisconsin [Mr. BYRNES], I am sure—and I think he has already stated so—has the same high degree of confidence in this actuary that I have myself. I have been dealing with him since 1942 on the Committee on Ways and Means.

Many times it has been a little difficult for me to believe that the tax rate should go as high as he said it had to go. I found that he was right and I was wrong. He has been completely objective; he has been completely accurate, so far as I know, in the estimates he has made to help guide our committee.

I cannot argue with the gentleman; he may be right. But I am telling him that we have the best actuarial judgment that tells us on the basis of high cost estimates that we are properly financing this program.

Mr. JONES of Missouri. The only thing I can go on is this. I have been in this House for 16 years. Each year I have had hopes that we were going to reduce the national debt and each year it has grown larger.

Mr. MILLS. I agree with the gentleman.

Mr. JONES of Missouri. The gentleman knows that we have talked about this, but we do not bring out a realistic figure. The debt continues to go up. We still think we can pay the debt by reducing taxes, but it has not worked. I hope that the same actuary that the gentleman has confidence in will start working for the administration and that they will try to get this debt down.

Mr. MILLS. The gentleman means that we need him in the Bureau of the Budget. Maybe we do. If the gentleman will yield further to me, I know that the gentleman realizes the difference in the choice that we have posed here this afternoon.

Mr. JONES of Missouri. I am not sure. That is what I have been wrestling with my conscience on for several days and I cannot come up with the answer.

Mr. MILLS. Let me think with the gentleman for just a minute. I pointed out how the moneys in this bill were obtained, and how they would be spent, the sources from which we would get those moneys, both from the trust funds and from the general funds of the Treasury. I pointed out that those items in this bill from the general fund of the Treasury are budgeted with the exception of one item, and that is the item of the Federal Government's participation in the supplemental health program to which the individual makes his monthly contribution.

The reason that is not budgeted is it does not go into effect until July 1, 1966. Let us take that; that is in this high budget that we are talking about. But the proposal of the gentleman from Wisconsin [Mr. BYRNES] does not use the payroll method for financing any part of this. His Government financing is all from general funds and we all know that the Government is now in a deficit position, so Mr. BYRNES' proposal would mean deficit financing. He says, "I want to do more than you want to do, Mr. Committee. You have not done enough. You have not included drugs that would be used any and everywhere or private day nursing service. You have not done things like that. I want these people to have these things and I am going to give them to them." I think he said that earlier in the course of the debate, that the benefits in his bill amounted to more. He tried to convince me. He did not do it yesterday and he has not done it yet—that is, that you can give people more and have it cost less.

Mr. JONES of Missouri. I agree with the gentleman.

Mr. MILLS. And I do not think he can convince my friend from Missouri about that. But even if it is going to cost the same under his bill, as it does under the committee bill, where does he get the money? Out of the general fund of the Treasury, this very fund that the gentleman has been trying to preserve and protect and to reduce the national debt. The gentleman from Missouri will not go for anything like that, I am sure.

Mr. JONES of Missouri. May I say this to the gentleman? I do not want to embarrass the gentleman by saying this, but I have great confidence in the Kerr-Mills bill.

Mr. MILLS. I do, too.

Mr. JONES of Missouri. I still have great confidence in that bill. I regret that we did not bring out four bills instead of this one. I could have gone down the line for three bills that could have been taken out of it, but the fourth one is the one that is causing me the trouble that is in this bill. The Kerr-Mills bill takes care of the people who need that care and they will get it. I think if we pass this bill we are going to discourage the States who have not yet come into it, and I do not think they will ever come into it.

Mr. MILLS. Mr. Chairman, if the gentleman will yield to me further, under

the provisions of the committee bill which are also included I think you are going to find that all the States will participate within just a very short period of time.

I believe the gentleman from Wisconsin [Mr. BYRNES] would agree with me on that. We are doing that for Kerr-Mills.

Mr. JONES of Missouri. I thank the chairman, and I want to reiterate the confidence I have in him. I have spent hours studying the various proposals; I want to provide the needed services, especially for those who cannot afford the catastrophic costs that accompany some operations and terminal illnesses. From a selfish standpoint I would be tempted to vote for this bill, and to guarantee myself a lifetime hospital and medical care insurance policy at a cost of about \$6 a month—but I have grandchildren who would be saddled with this debt all of their lives, and I do have concern for them and other young people.

The difficulty I have been experiencing is trying to justify voting for a bill which I believe in my heart is not only inadequately financed but which puts a much greater proportionate burden on those least able to pay and gives to the more fortunate a bargain-rate program, a large portion of which will be financed out of the Public Treasury which is going deeper in the red each year.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield such time as he may consume to the gentleman from Minnesota [Mr. QUIE].

(Mr. QUIE asked and was given permission to revise and extend his remarks.)

Mr. QUIE. Mr. Chairman, I would like to take this opportunity to ask the chairman of the Committee on Ways and Means, the gentleman from Arkansas [Mr. MILLS], a question, if I may have the gentleman's attention, with respect to the provision contained in the bill designed to change the definition of "disability."

I have heard from some of my constituents who are concerned about this change in definition which liberalizes the definition of "disability."

They are particularly concerned about the overlapping of benefits to a person who is disabled with respect to the workmen's compensation plans in the various States.

I was wondering if the gentleman from Arkansas could illuminate a little more on his initial comments with reference to this subject as contained in his opening statement on yesterday?

Mr. MILLS. Mr. Chairman, will the gentleman yield?

Mr. QUIE. I yield to the gentleman from Arkansas.

Mr. MILLS. I shall be glad to respond. There is, to some extent—how significant it is we do not know yet—some degree of overlap between the disability benefits that are paid under the Federal program and some of the benefits which are supplied by the State Workmen's Compensation Acts of the various States. To the extent that we may have provided disability benefits for an additional 155,000 workers and dependents, as we do in the committee bill, we may have included

some others where there would be an overlapping. We just do not know.

But we were concerned about the matter in the committee. I would direct the gentleman's attention to the committee report and the gentleman can find this covered in the paragraph dealing with this subject matter on page 90 where we take notice of this situation. We were disturbed somewhat about the manner in which it appears to work so we have called upon the Department of Health, Education, and Welfare to meet with the people handling workmen's compensation, and others, and report back to us, giving us more factual data than we have available today so that we might better know how to proceed with respect to this problem, if it develops that it is serious enough to justify such action.

Mr. QUIE. The gentleman and his committee expects a report from the Council before December 31, 1966, so that if they do find sufficient overlapping, corrective action could be taken prior to the end of this Congress?

Mr. MILLS. If the gentleman from Minnesota will look further down on that page, the next paragraph, the gentleman will see that we requested that the report covering the results of this study, and such other facts relating to the problem as are found relevant, be made on or before December 31, 1966. It would be available, therefore, for the next Congress.

Mr. QUIE. So the gentleman does not contemplate any action on this until after that deadline date?

Mr. MILLS. I would not want to be specific either way. If the report comes to us before this date, we shall consider it as our schedule permits and certainly we expect to receive it by that date.

Mr. QUIE. If they should find in the early days of their study some dramatic instances of overlapping, we could expect that there would be a report on that?

Mr. MILLS. Yes, I would expect such a situation to be called to our attention at an earlier date.

Permit me to point out to the gentleman that because of this very situation that has been called to the gentleman's attention, we did specifically prevent the overlapping with respect to workmen's compensation and both of the two new medical programs.

Mr. QUIE. And with respect to the next program, did the gentleman and his committee hear from anyone during the committee hearings in regard to the insurance field or from any representatives from industry at all?

Mr. MILLS. Yes, we heard, and I am sure other members of the committee have heard, from many people about this, and from the insurance industry as well as other industries. People connected with State workmen's compensation also have written me about it.

Mr. QUIE. Is there anything in the hearings about it?

Mr. MILLS. I am told that there is a reference to it in the hearings by some representative of the insurance industry. It is in one of these two volumes.

Mr. QUIE. Rather than take the time now, will the gentleman extend his re-

marks at this point, and put it in the RECORD?

Mr. MILLS. I will be glad to. The following is an excerpt from the testimony of J. Henry Smith, vice president, Equitable Life Assurance Society, of the United States—page 393, printed executive session hearings on medical care for the aged, February 4, 1965:

Section 1809(e) prevents payments in certain circumstances where duplication of benefits would otherwise result. We recommend extension of this sound antiduplication principle to other areas such as workmen's compensation, occupational disease or similar benefits, and benefits paid under voluntary health insurance.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield 1 minute to the gentleman from Ohio [Mr. LATTA].

Mr. LATTA. Mr. Chairman, I take this time to pose a question to the chairman of the committee, the gentleman from Arkansas [Mr. MILLS].

In this bill we are making certain changes in the widows' benefits. I would like to ask this question of the chairman: Suppose a widow is married to her first husband for more than 20 years. After his death she remarries, and her second husband is killed on their honeymoon. Can she elect to take benefits under her first husband's account?

Mr. MILLS. The answer to the gentleman's question is, "Yes." She was married to the second husband for a period of less than 20 years?

Mr. LATTA. Yes.

Mr. MILLS. She could resume her benefits on the basis of her first husband's work record.

Mr. LATTA. I thank the gentleman.

Mr. MILLS. Mr. Chairman, I yield 3 minutes to the gentleman from Ohio [Mr. MOELLER.]

(Mr. MOELLER asked and was given permission to revise and extend his remarks.)

Mr. MOELLER. Mr. Chairman, in spite of all that has been said against this legislation, particularly relative to the burden it will place on our young people of today, I say that our children and our children's children will rise up someday and call us blessed for passing this legislation.

In my professional life I have dealt almost daily with sick people. Not only spiritual problems confronted these people. Also weighing heavily on their minds was the problem of how they would pay hospital bills and how they were going to pay doctor bills. Those were serious problems. But, H.R. 6675 gives us the means to correct a bad situation and lift this mental plague.

We have heard much, Mr. Chairman, about what can be done through other kinds of legislation, but I fear that a lot of misinformation has been circulated with respect to the medical bill. If the chairman of the committee will reply, I would like to ask him two questions. No. 1, does Ohio qualify for assistance under the present Kerr-Mills legislation?

Mr. MILLS. It is my understanding that the State of Ohio has not implemented this program. I was told that is right. They do have old-age assistance, however.

Mr. MOELLER. If Ohio does not participate in the Kerr-Mills legislation, what benefits would the citizens of Ohio beyond age 65 get if the so-called elder-care bill had been passed?

Mr. MILLS. They can get no benefits under the so-called eldercare bill until the State has implemented the program.

Mr. MOELLER. In other words, the effort being put forth back in Ohio trying to sell our people on the idea of eldercare, and you know who is doing this, is misleading and false information to our elderly citizens?

Mr. MILLS. It is not a Federal program solely. It is a Federal-State program, a Federal program of assisting the States, just as the Kerr-Mills Act does.

Mr. MOELLER. Yes. So, even if passed by Congress there would have been no benefits of any kind in the eldercare bill for the people of Ohio unless the State implemented it.

There is also a very sane and moral position to hold with respect to this legislation. There is no nation on earth which gives away so much money per year under welfare programs as does the United States. Now, this program is going to call on people to start laying aside a little money in their employable years, to put aside funds for a rainy day, to become self-reliant in their later years. Is that not correct, Mr. Chairman?

Mr. MILLS. Yes; that is the way I look at it.

Mr. MOELLER. Now, Mr. Chairman, we are approaching the moment that I have dreamed of and worked toward for a long time. We are getting ready to pass the medical care program for the elderly—and I am confident that we are going to pass it by a truly fantastic majority.

This vote will serve unmistakable notice that the House of Representatives will not be and cannot be intimidated or browbeaten by the ruthless cynics who control the American Medical Association.

Down through the years, the American Medical Association has spent countless millions of dollars to defeat urgently needed and compassionate health programs—to slam the hospital door in the face of the elderly—to throw up one roadblock after another in the steady march of medical progress.

I am talking now about the leadership of the American Medical Association, the little group of cynical men who have appointed themselves as would-be czars of the health and welfare of this Nation.

I know personally that many doctors are as contemptible of the leadership of the American Medical Association as I am; I have been personally assured by a large number of doctors in my 10th Congressional District that the bill we debate here today—H.R. 6675—is vastly superior and infinitely more desirable than the so-called eldercare proposal.

Mr. Chairman, the latest drive by the leadership of the AMA to retard medical progress was doomed to defeat from the start. For its slick propaganda campaign was built on a foundation of exaggerations, deceptions and outright falsehoods. The truth crushed to earth,

even by the officialdom of the AMA, always rises again.

I am not surprised in the least by the tactics employed by the American Medical Association against the medical care program for the elderly. It has a long and sorry record of blind opposition to any legislation, to any program designed to promote the health and welfare of the ordinary people of this Nation. Let us look at the record:

In 1930, the American Medical Association branded as "communistic" the Sheppard-Towner Act for maternal and child health, for crippled children, and for child welfare. For good measure, the AMA denounced this compassionate program as "Federal bureaucratic interference with the sacred rights of the American home."

In 1939, the editor of the Journal of the American Medical Association condemned the old-age assistance program as "a definite step toward either communism or totalitarianism." He charged that the social security program represented "the first breakdown of American democracy."

Later, the American Medical Association bitterly opposed the extension of social security benefits to the permanently and totally disabled at age 50. The AMA somehow managed to see this refinement as constituting "a serious threat to American medicine."

When Congress eliminated the means test in the crippled children's program the American Medical Association was beside itself in denouncing this step as "socialistic."

The American Medical Association fought against the creation by Congress of free diagnostic centers for tuberculosis and cancer. These centers were viewed by the AMA with its usual alarm as "unwarranted socialization" and "an encroachment upon the field of medicine."

We have heard a great deal from the American Medical Association about the virtues of voluntary health insurance. Such, of course, was not always the case.

The Journal of the American Medical Association, in 1933, condemned group hospitalization plans as "half-baked experiments in changing the nature of medical practices." The Journal also described voluntary health insurance as promoting "socialism and communism—inciting to revolution."

In 1950, an authorized spokesman for the American Medical Association denounced as "impractical and harmful to national defense" a plan before Congress to guarantee medical care for dependents of men in the Armed Forces, including those fighting in Korea.

The list of healthful and necessary medical programs that the American Medical Association has seen fit to brand as "socialistic" or "communistic" or "totalitarian" or "dangerous" goes on and on.

Fortunately, neither Congress or the overwhelming majority of the American people have been taken in by these pronouncements of doom from the American Medical Association.

Mr. Chairman, I am especially glad today that my constituents saw fit to return me to Congress as their Representative. They have given me the opportunity to do what I said I would do in my campaigns of 1962 and 1964, and that was to help pass a medical care program for the aged.

I recall that in 1962, when I advocated a medical care program, I was attacked and vilified as a "Socialist," as one dedicated to destroying the freedom and liberty of our people. The campaign against me was so lacking in any semblance of fairplay that it attracted nationwide attention, as an example, I suppose, of the lengths that the AMA will go to punish anyone who refuses to kowtow to its dictates. In any case, Drew Pearson finally exposed those who were behind this scheme to destroy me.

It is with great pleasure, Mr. Chairman, that I repeat my firm support of H.R. 6675 and urge its passage. I am sure that this legislation will in a short time rank in acceptance and popularity with the Social Security Act and other measures that have contributed so much to the health, happiness and security of the American people.

Mr. MILLS. Mr. Chairman, I yield 3 minutes to the gentleman from New Jersey [Mr. KREBS].

(Mr. KREBS asked and was given permission to revise and extend his remarks.)

Mr. KREBS. Mr. Chairman, during the course of the debate on this bill, we have heard from a few opponents to medicare legislation that this bill is not the right approach to this problem. Some of these remarks bring back to my mind my own campaign a few months ago in which I indicated my support of medicare. During the hectic days of campaigning we were told by the medicare opponents that this bill was not needed.

I replied that the 19 million elderly Americans are proof of the need. Approximately only half of those have hospitalization insurance, and half of those so insured hold policies that inadequately cover only hospital care.

It is no secret that 80 percent of the elderly suffer from chronic ailments; that these older citizens require at least three times as much hospital care as younger people; that 90 percent of those over 65 years of age require hospitalization at least once and their hospital stays are nearly double the duration of those for younger people.

Thus, today the person over age 65 can anticipate an average hospital stay of about 15 days as compared to the average 7 days for those under 65.

That the need for this legislation exists, therefore, cannot be doubted by any reasonable person who wants to look at the facts.

Looking further into the hard facts, we see that to pay for these inevitable hospitalization costs, at least 91 percent of the single, elderly persons have an income under \$3,000. Among the married elderly couples, 29 percent are estimated to have less than \$2,000 income, and 80 percent have less than \$5,000.

When it is shown, as indeed it has been adequately demonstrated during this debate, that a full one-tenth of our population is directly affected by the ever-increasing health costs to be paid out of the ever-decreasing income, then I say it is time for the Nation to come to grips with this problem.

I believe this bill represents a sensible combination of social security experience with Kerr-Mills legislation, that in the past has received the support of important segments of the medical profession. The Ways and Means Committee is to be commended for the thoroughgoing work that went into the drafting of this bill, and I rise today in support of that bill which the gentleman from Arkansas, Chairman MILLS, has so ably guided through the debate.

I would say to my colleagues on the Republican side of the aisle who made reference to the negligible effect the amount of \$4 could have, which would be given to the recipients, when you compare \$4 to the millions of dollars the American Medical Association has spent in opposition to this legislation, and when you compare this \$4 to the \$74 received by recipients of social security, it represents a 5-percent increase, I say this 5 percent is equal to a pint of milk a day for everybody over 65, and I think this can very well make the difference between their good health or the lack of it.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield 12 minutes to the distinguished minority leader, the gentleman from Michigan [Mr. FORD].

(Mr. GERALD R. FORD asked and was given permission to revise and extend his remarks.)

Mr. GERALD R. FORD. Mr. Chairman, I have listened with great interest to the debate on the measure now before us which would make many significant improvements in our social security system and which would also provide a three-tier approach purportedly to improve the health care security of our aged.

For the most part, the improvements that would be made under this legislation are meritorious and desirable. I am sure that they have the support of virtually every Member of this body. Such improvements include the cash benefit increase, continuing benefits for young people up to age 22 who are in school, the liberalization in the retirement test so that our aged will have greater freedom in determining the extent to which they want to continue working, the changes in the coverage opportunities for certain of our citizens who are over age 72, the strengthening of the public assistance titles of the act, and the voluntary health insurance program.

Most, if not all, of these improvements were included in a bill introduced by the able ranking minority member of the Committee on Ways and Means early in January. These improvements could have been enacted long ago if the administration had not insisted that the controversial compulsory medicare plan had to be a part of any social security package. In fact, these specific im-

provements to which I have alluded largely could have been enacted last year with substantial Democrat and Republican support—and did in fact pass the House—but final action was thwarted by the advocates of compulsory medicare.

During the portion of the debate that occurred yesterday, there were some overtones of partisanship. They were few, but they did occur. When they did occur, I could not help but wonder whether the spokesmen were being more interested in politics than in people. To me, the legislation before us is not a political issue; it presents the honest question of how best to deal with a recognized problem in a manner that meets the tests of adequacy, fairness, and effectiveness. Compassion for the aged and concern for the taxpayers are without party labels. The entire membership of the Committee on Ways and Means—Republican and Democrat alike—warrants the commendation of the House of Representatives for the diligent effort that has been devoted to the development of this legislation. I believe it is also appropriate to recognize the fact that many other Members of the House who do not serve on the Committee on Ways and Means have made constructive contributions to this legislation by the thought and advocacy they have given to approaches to dealing with the problems of our aged.

Thus, in a short time we will vote. I would like to suggest that we recognize that our votes are not for or against an adequate social security system nor is there involved the question of: Should our aged receive adequate health care? Rather, the vote is on which alternative do you prefer. It is with respect to those alternatives that I would like to address the balance of my remarks.

I have said that this bill would provide a three-tier program to finance the health care requirements of our aged. One tier involves the existing Kerr-Mills program and would strengthen it by adopting the essential elements of the eldercare proposal so that our needy aged can be assured of comprehensive medical assistance under State administered programs. This tier has virtually unanimous support.

A second tier is based on a plan originally advanced by the gentleman from Wisconsin [Mr. BYRNES] and his Republican colleagues on the Committee on Ways and Means. It would provide a voluntary system of health insurance available to the aged that would recognize ability to pay and not involve the imposition of a payroll tax on the working population. This second tier is taken from a Republican proposal, as I have said, and has been adopted by the Democratic administration, praised by the President, and approved by the members of the Committee on Ways and Means. In the order of things as this second tier appears in the committee's bill, it is referred to as the voluntary supplementary plan.

The third tier is referred to as the basic plan and it is the administration's so-called medicare proposal. It is compulsory, is financed by a payroll tax, and

provides only limited benefits in a restricted range of health services.

Mr. Chairman, when it is realized that the proposal advocated by the Republican members of the Committee on Ways and Means would strengthen the existing Kerr-Mills program and would establish a more comprehensive voluntary system of health insurance for the aged, the question inescapably arises why are some people insisting on this third tier—the medicare approach? When that question is asked, the issue becomes clear. It brings into sharper focus what the proponents of medicare are really advocating. They are not advocating the only way in which the aged can be protected against the economic adversity of illness because the Republican alternative—which has been endorsed in principle by the Democrats—gives the aged more comprehensive protection. The medicare proponents are not advocating the only way to adequacy, economy, or efficiency in a health care program because I submit to you that the Republican alternative based truly on the insurance concept is the proven and time-tested way. What then are the medicare proponents really advocating? They are proposing compulsion and higher payroll taxes and that alone. Compulsion and regressive payroll taxation are the essence of their approach to this matter.

If compulsion is so necessary, why do not the medicare proponents have the courage of their convictions and go all the way with it? Why should they tolerate any voluntary aspect in the program? If payroll taxation is so sound, why do not the medicare proponents go all the way with payroll taxation to finance the entire program? Under the dual hodgepodge system that the medicare advocates have put together, we are going to find our aged bewildered by a multiheaded bureaucratic maze of confusion over what program covers what and who is on first base. Many of the aged will learn too late that their health needs are being only partially met by the plan of so-called insurance imposed upon them under medicare. The compulsion in medicare can only mean compelled confusion rather than improved protection for the aged.

Mr. Chairman, during the past 2 years we experienced the pleasant novelty of witnessing the Democratic Party embracing the traditional Republican concept that lower taxation would encourage economic growth. The Congress was urged to approve a tax reduction program to advance the economy on the promise of spending restraint and we did, although the expenditure restraint has failed to materialize. Presumably, later this year we are going to have the opportunity to bring out a reduction in certain excise taxes—again as an economic stimulant. Just the other day, the distinguished new Secretary of the Treasury said that tax cuts can help our Nation solve its very serious balance-of-payments deficit.

I wonder if the Secretary of the Treasury knows about this bill. In significant part, this bill will be responsible for social security payroll tax collections for

1966 exceeding by almost \$5 billion the amount to be collected with respect to the current year. These increased taxes will not be premised on any concept of ability to pay. They will be imposed at a higher rate applicable to a higher taxable base as virtually a gross income tax; they will be imposed at the low end of the income scale on the working population to pay health care expenses for the elderly population in total disregard of the substantial ability of many of the aged to provide for themselves. To the Secretary of the Treasury I say, "Mr. Secretary, what does the major tax increase under this bill do to your urgent endeavors to deal with our critical balance-of-payments situation?" We might also ask ourselves how the war on poverty will be advanced by increasing the cost of employment and do we really help Appalachia when we make it more costly and difficult for our domestic steel producers to compete with imports? I submit, Mr. Chairman, that we are rapidly reaching the point where we have more programs than we have policy, where we have more solutions than we have consistency.

Mr. Chairman, in attempting to justify the medicare approach, much is made of the fact that by imposing what will ultimately be a tax of up to \$740 a year on a worker and his employer, we will have a funded system that provides for prepayment of protection. One need only read the Republican views in the committee report to recognize the fallacy in these assertions. The program is not funded and in fact medicare will add billions and billions of dollars to the already staggering unfunded obligations of the OASDI program of the social security system. There will be no prepayment because the taxes paid today will be used to provide benefits for those persons currently aged and the future security of the present working population will be contingent on the willingness of the workers at that time to bear the burden of the higher taxes we are imposing on them.

Much has been made of the fact that there is some magical safeguard involved in providing a separate payroll tax and a separate trust fund for the medicare program. Mr. Chairman, I submit that the exigencies of tomorrow arising from the expediency of today will prove these so-called safeguards mere myths. The American people will not distinguish the OASDI cash benefits from the medicare service-type benefits. Both are being provided in the same bill. The taxes the people pay will apply to the same earned income and the debts we leave to the next generation will comprise one encumbering burden regardless of how we attempt to compartmentalize the debts by nomenclatures. Therefore, regardless of the various labels that we may subscribe to today to distinguish between the cash benefit program and the service benefit program, the danger that medicare poses to the ability of the OASDI program to meet its cash benefit obligations cannot be denied. In support of my contention that these trust funds are not inviolate, I need only point out to you that in this bill now before us is a provision increasing the allocation of funds to the dis-

ability trust fund to the detriment of the old-age and survivors trust fund.

Mr. Chairman, the arguments against the medicare approach and in favor of the approach contained in the Republican alternative could be discussed at considerably more length than I will take today. These arguments have been well stated by people who have preceded me in this debate and will also be discussed by those who follow me.

It does seem to me that with the Democrats having embraced the Republican approach in substantial part, they have an obligation to explain their apparent inconsistency in insisting on both the compulsory approach and the voluntary approach. They have an obligation to explain why they use payroll taxes in part and other financing methods in part. Some of the Members from the other side of the aisle have an obligation to explain why a proposal that seemed unsound last year is suddenly sound this year.

Mr. Chairman, it will be my purpose to support the Republican alternative embodied in the motion to recommit. It is to be recognized that on this particular issue under the existing parliamentary situation, such a vote in my judgment is not a negative vote but is, indeed, a positive vote for an improved bill that treats our retired people more adequately and our working citizens more equitably.

I conclude with these observations. The House Republican Policy Committee and the House Republican Conference have endorsed H.R. 7057, the Byrnes bill, as the motion to recommit. H.R. 7057 was unanimously endorsed by all of the Republican members of the Committee on Ways and Means. I commend the Republicans on the committee for their hard and constructive work. I especially commend the gentleman from Wisconsin, Congressman JOHN BYRNES, for his leadership in drafting H.R. 7057 which is constructive legislation, far preferable to the committee proposal.

As far as final passage is concerned, if the motion to recommit fails, neither the House Republican Policy Committee nor the House Republican Conference have recommended any guidelines. This is quite understandable. The committee bill, H.R. 6675, is to a substantial degree Republican legislation, except that part which incorporates the administration's King-Anderson proposal for hospital care financed by a payroll tax.

Many of my Republican colleagues, in weighing the Republican portions of H.R. 6675 against the administration's part of the same bill, with understandable logic will vote for the bill on final passage. On the other hand some of us, including myself, have strongly and consistently opposed the regressive payroll tax method of financing hospital care for the aged.

In my judgment that portion of H.R. 6675 which is unsound, outweighs the good. In the final analysis it is one's own conscience, not a Republican policy position, that will determine how Republicans will vote on final passage.

I conclude, however, by reemphasizing that the Republican motion to recommit

is sound. It is our policy as a party. I urge that my colleagues support the Byrnes substitute, H.R. 7057.

Mr. MILLS. Mr. Chairman, I yield 10 minutes to the gentleman from Oklahoma, the distinguished majority leader [Mr. ALBERT].

(Mr. ALBERT asked and was given permission to revise and extend his remarks.)

Mr. ALBERT. Mr. Chairman, I join the distinguished and able Republican leader [Mr. Ford] in commending the outstanding performance of the members of the Committee on Ways and Means in preparing this bill and presenting it to the Members of this House and of this committee. I doubt that in all the history of the Congress a bill has been more thoroughly considered or more thoroughly debated. I doubt that ever before the quality of debate on any bill has been more penetrating or more cogent than it has been on this bill.

The gentleman from Michigan [Mr. Ford] has properly paid tribute to all the members of this committee. The accolades which have been accorded to the distinguished chairman of this committee by Member after Member only begin to suggest the compliments which this House and this country owe him for the job he has done in shepherding this bill through the committee and through the House.

Typical of the work of the distinguished gentleman from Arkansas, this bill represents tremendous effort, matchless ability, and sincere dedication.

When I first came to the Congress I was told that back in the very early days of social security when a bill was tied up in the great Committee on Ways and Means, the rising star from Arkansas first demonstrated before the House his genius for handling difficult legislation. The distinguished gentleman from Arkansas [Mr. MILLS] worked out the solution which made possible the enactment of one of the great early social security bills. He has continued to develop these great skills and this body and the entire country have been well served as a result.

I cannot agree with my distinguished friend from Michigan on that portion of the bill which he opposes. I have heard this argument about the payroll tax being repressive ever since I can remember hearing about social security. I have heard the argument about its being involuntary ever since the first social security message was sent to the Congress. I have heard the argument, yes, although it has been softened somewhat, about its being socialistic. But I have never in my lifetime seen any senior citizen of this country drawing a social security check who did not believe that social security was one of the finest things the Congress of the United States ever did for the senior citizens of this country. Our citizens are willing, and I think the employers of this country are willing to increase the payroll taxes, through a new tax, under a separate account, in order to enact into law the benefits of that portion of the bill which come under the social security tax provisions. I am sure that all those who have given it reasonable consideration favor this proposal.

As for this matter having been properly considered, in the first place I know the extent to which the gentleman from Arkansas considers this type of legislation. I know how well he does his homework. When the gentleman from Arkansas brings out a bill it is well prepared and well considered. This was true of the tax bill last year. It was true of the trade bill. It has been true of every bill managed by the distinguished gentleman from Arkansas. He and his committee, in my opinion, have minutely examined every possible fiscal taxation, actuarial element involved in this measure. Knowing the chairman and his committee as I know them I am confident that they have consulted the Secretary of the Treasury, the Bureau of the Budget, the Social Security Administration, the President's economic advisers, and all those who could make contributions in this matter. This is a great, progressive bill. This is a bill for humanity. This is a bill for people. This is a bill which the American people want and they want it enacted in 1965.

This bill, I say to my colleagues, Republicans and Democrats alike, is a bill which in my opinion will serve well those of us who support it, politically and otherwise, through the years. This is landmark legislation which offers a truly unique opportunity to serve millions of older Americans.

Mr. Chairman, this legislation is sound. It is just. It is past due. I hope it will be enacted by an overwhelming vote.

Mr. MILLS. Mr. Chairman, I yield such time as he may consume to the gentleman from Texas [Mr. FISHER].

(Mr. FISHER asked and was given permission to revise and extend his remarks.)

COMPULSORY TAX FEATURE OF MEDICARE BILL IS FRAUGHT WITH DANGER

Mr. FISHER. Mr. Chairman, I hold in my hand a letter from a Texas constituent, in which he states:

I have a mother, mother-in-law, and an aunt, who have benefited under the Kerr-Mills plan. They do not have an income at all. Two of these are in a rest home. The other has had a major operation, in hospital for 15 days. Kerr-Mills takes care of these without expense to me. This plan helps those that really need it.

It would appear from this that the Kerr-Mills plan of aiding needy elderly people in meeting their hospital and medical costs is fairly adequate, or at least can be made that way if and when deficiencies arise.

We all recognize the obligation society owes to elderly people who are faced with hospital and medical bills they are unable to pay. And there should not, of course, be any semblance of a "pauper's oath" required in order to get it. That objective is attainable under the Kerr-Mills plan. Because of that sense of obligation to these people, I voted for the Kerr-Mills Act when it was approved in Congress 5 years ago. Under it the Federal Government makes substantial grants to the States to help finance the cost. It is administered by the various States which choose to make use of it.

This approach appeals to me because it divorces the Federal Government from

the management and operation of the program, and when properly implemented by the States it can function successfully and adequately. That fact has been demonstrated. The very manner of its administration constitutes a built-in guarantee against the socialized medicine concept. And it is much less expensive than what is now being proposed.

Then why the necessity for another approach, costing the taxpayers billions of dollars? Can we afford the luxury of financing two of these health programs at the same time? The taxpayers I hear from seem to think the cost of Government is already too high. They would like to see tax reductions, not tax increases. Someone suggested that the increase in social security taxes under the pending bill would be about like increasing personal income taxes by 10 percent on the average taxpayer—perhaps even more.

Now what will this new concept cost? There are around 20 million people over 65 who would benefit from the pending bill. This number includes the rich, the poor, and those with moderate incomes. Yet whether they need it or not, everyone will get the same benefits. Official estimates are that it will cost \$35 billion to finance hospitalization for these elderly people.

This program is to be financed by a compulsory increase in the payroll taxes. Under the pending bill that tax will gradually increase until it reaches the total of 11.2 percent. This is an alarming increase, and undoubtedly puts the stability of the social security system in jeopardy.

This payroll tax will be applied to the first \$6,600 of income from wages. Even the wage earner who makes only \$3,600 a year will find his social security taxes exceed his income tax each year. That wage earner, with a wife and two children, will pay a total of \$250 a year in 1966, including income and payroll taxes, of which \$162 will be on the wages and \$18 of it will apply to hospitalization.

It is pointed out in the committee report that under the pending bill, a worker entering the work force at the age of 21 will pay his tax for 44 years—matched by his employer. The actual cost of the hospitalization program per worker, of this 21-year-old person, with interest at 3½ percent per annum, will total \$8,590. That will be paid, under compulsion, to help finance hospital benefits for those already retired. And it is pointed out that the same amount invested in private health insurance would provide the worker with far more extensive benefits than are provided under the hospital program as contained in this bill.

Another significant point that is made refers to the prepayment concept in the bill, which the minority characterizes as a myth. It is pointed out that when the 21-year-old worker becomes 65, there will not be \$8,590 waiting for him, to finance his hospital needs. That money will have been used to pay benefits for those who preceded him. Indeed, the estimated set-aside will cover the cost of only 1 year's benefits.

The most serious and dangerous aspect of the medicare proposal, as I see it, is the financing method. This follows the pattern employed to finance socialized medicine in Britain, France, Holland, and elsewhere. That method of financing has weakened the integrity of the social security systems in some of those countries. The Minister of Health in France, for example, recently said their system was facing bankruptcy because of the burden of the medicare feature.

It has been the history of these programs, financed through social security taxes, that they start out on a modest basis, then grow and grow until there is coverage for everybody—rich and poor, sick and well. And along with the strain of finances there has been a deterioration of the quality of both medical and hospital services in practically every country that has gone in for state medicine. Will history repeat itself in this country? This will, of course, depend largely upon how much expansion there is to be in the future. That calls for an examination of the motivations of the architects of this compulsory system.

Former Congressman Aime J. Forand, a chief supporter of this method of financing hospital costs, explained the ultimate goal in January of 1961, in these words:

If we can only break through and get our foot inside the door, then we can expand the program after that.

Walter Reuther, another of the prime architects of this method, said in Atlantic City last year, he favored "a national health plan to provide comprehensive medical care for all Americans without regard to their ability to pay for it."

Former Postmaster General Edward Day, who was in the Kennedy cabinet, who opposes the pending method of financing health care, in an article in *Nation's Business* last year, foresaw pressures to expand coverage once the compulsory financing scheme is put into effect.

A spokesman for the Socialist Party in the United States was recently quoted as saying such a system would be "capable of indefinite expansion until it includes the entire population."

Mr. Chairman, I certainly do not question the motives or the good faith of the members of the Ways and Means Committee who reported this bill. I am sure they would not want the coverage to expand in the manner proposed by Mr. Forand, Mr. Reuther, and others. But these members will not always be around to act as watchdogs. In the natural evolution of things we simply must assume that once the compulsory feature is adopted, there will be constant pressures to expand it. The Assistant Secretary of Health, Education, and Welfare, Mr. Wilbur Cohen, now in office, an advocate of this method of financing medicare, once told a Senate committee that he favored a social security payroll tax of 20 percent on a wage based on \$9,000 per year.

Once this compulsory tax method is adopted, we must assume that there will in the future be candidates for Congress

who will say to voters: "Look, you are paying heavy taxes for medicare. You pay it every year, whether you want to or not. If you do not pay it they will put you in jail. Yet, if you get sick the Government will not pay a dime on your hospital and doctor bills unless you are at least 65 years of age. You are paying for it now and you are entitled to the benefits now. Elect me to Congress and I will go to Washington and try to get some justice for you."

Reacting to pressure groups, political platforms of both major parties will probably soon begin to include planks calling for expansion of medicare coverage in the future.

Mr. Chairman, there is no point in belaboring this issue. It is so important that we take this step with our eyes open. We have in this country the most advanced and efficient medical and hospital service in the world. We know from the experience of others that political medicine is not good medicine. We know something of the risks that will be taken by getting the foot inside the door. We will be embarking on a dangerous course, despite good intentions, which can be quite disastrous. Because of my opposition to the medicare feature of this bill I shall be constrained to vote against it.

Mr. BYRNES of Wisconsin. Mr. Chairman, I yield myself 10 minutes.

(Mr. BYRNES of Wisconsin asked and was given permission to revise and extend his remarks.)

Mr. BYRNES of Wisconsin. Mr. Chairman, I would echo the sentiment of the majority leader expressing a certain satisfaction with the method in which the debate on this bill has proceeded, and I think it has been on a very high level.

Mr. Chairman, I am not too sure how much that debate, however, has influenced any votes. But I think it has made a clear record of the issues and of the problems and of the area of agreement that are involved in the legislation that is now pending before us.

Mr. Chairman, the gentleman from Arkansas [Mr. MILLS], chairman of the Committee on Ways and Means, however, has suggested a short while ago that I still had not convinced him, and apparently I had not convinced some others with respect to how we could present, as we do in the alternative program, a better medical package at less cost to the general taxpayers.

Mr. Chairman, if I might borrow, therefore, from the words of our President which I believe are words taken from the Bible, "Let us reason together," I would like in these few remaining minutes of this debate to try to reason with the gentleman from Arkansas and some others as to how this is possible.

Let me to say to all of my colleagues that I have been as interested in getting the true cost of both programs as anyone could be, because I believe that is an important element. I am fearful, however, that there are some who while professing to be interested in the costs involved, have been a little more concerned with trying to blow up the cost of the substitute proposal simply as a means of

discrediting it. As a fundamental proposition I believe they will have difficulty in discrediting it in view of the fact that the majority on the committee have accepted the underlying principles of the substitute bill, that of being voluntary and that of being contributory. These are fundamental parts of the committee bill. They have adopted from us—and I support them in doing so—a proposal to take care of supplemental medical benefits under a voluntary contributory system. But while adopting these principles, they point to the overall cost of the substitute package as being the inherent evil.

We had for instance, Mr. Chairman, a very odd situation yesterday where we had been given an official, and what I thought was a final estimate, by a recognized actuarial expert as to cost of my bill.

We had up until yesterday what we thought was a firm and a final estimate from the chief actuary of the Social Security Administration as to the cost of the proposal I had made. That estimate was submitted in a letter of February 26, a little more than a month ago. But then, yesterday I was informed, and this body was informed by the chairman of the Committee on Ways and Means, that as late as the day before, on April 5, he had obtained a new memorandum containing a new estimate of the cost of my bill. I must confess that this came as a surprise to me because I have been trying to keep close to this legislation, hoping to make some contribution to it, and I did not know that information would be presented here that had not been made available to the rest of the members of the committee.

Even yesterday, I thought when the chairman called my attention to that memorandum of April 5, that this would be the last word; that the actuary had finally made up his mind as to what the substitute proposal would cost.

But, lo and behold, in this morning's RECORD we find a further revision of the estimate in the form of a memorandum from the chief actuary of the Social Security Administration, dated April 7—that is yesterday. Whether the chairman had that memorandum during the course of our debate yesterday or whether that memorandum was prepared after the debate, I do not know, but to my great surprise in the RECORD this morning I find even a later estimate. Whether I will find another estimate after today's debate, when I read tomorrow morning's RECORD, or a couple of days from now, I do not know.

At the close of my remarks, Mr. Chairman, I will place in the RECORD a copy of the letter which I directed to the chief actuary under date of February 12, this year, and a copy of his reply under date of February 26.

You will note in that letter I sought to clarify the prior estimates and asked him to give me an estimate of what he in his judgment, not mine, estimated the cost of my bill would be during the first full year of operation. I did not give him any assumptions because he is the expert, not I. I did not ask him for any self-serving estimate. I wanted to know

as near as the actuary could tell me what my bill would cost during the first year it was fully operative.

Here is what he said:

If there were 100 percent participation, the Federal cost for the first full year of operation (which could be assumed to be fiscal year 1966-67) is estimated at \$2.4 billion, while the participants themselves would contribute about \$1.25 billion. With 80 percent participation, the Government cost would be \$1.9 billion, while the participants would pay \$1 billion, and with 50 percent participation the corresponding figures would be \$1.2 billion and \$0.6 billion, respectively.

I should point out here also that in a prior estimate he recognized that complete participation, that is 100 percent, will never come about because of the parallel existence of other health insurance plans for persons under the Civil Service Retirement Act, health insurance for retirees provided by their former employers, and for other reasons. Of course, you are not going to get 100 percent participation. With that in mind, the \$2.4 billion, which he estimated as the cost to the general revenue, was high.

I do not know what assumptions the chairman of the committee requested the actuary to make in estimating the cost under H.R. 6675, or what assumptions he asked him to make with respect to his later estimates of the substitute bill. I do not know in fact whether the same assumptions would be valid to the proposal I made because there are different approaches which the committee bill takes as compared to my bill. All I can say is that I left the whole question of actuarial estimating of the cost of the actuary of HEW. He made the assumptions. I did not know and I do not know what assumptions he would make with respect to the cost of H.R. 6675—or with respect to the cost of my bill.

The fact of the matter is, however, it is acknowledged that the committee bill will cost the taxpayers about \$2.8 billion, and the actuary estimates our bill will cost the taxpayers about \$2 billion.

Let me go into the question of why there is that difference. Maybe we can get an understanding here between ourselves where there will be recognition of the fact that the substitute proposal costs less. There has to be a difference in the cost of the two bills.

While the insurance benefit package of the two bills differ, I have been reliably informed that the cost of the two benefit packages, as insurance packages, was approximately the same. There are some benefits in the committee bill that will cost more, frankly, than in the substitute bill. There are some items in the substitute bill that will cost more, such as the item of drugs.

For instance, even as to the hospital benefit, after the payment of the deductible under the committee bill, their program pays the full hospital cost for a longer period than does the substitute bill. The committee bill pays all of the costs for 60 days. The substitute bill, however, does not have a cutoff point. We continue to pay hospital benefits beyond 60 days, but after the first thousand

dollars of benefits the hospital cost is financed on a coinsurance basis, with the patient paying 20 percent and the insurer paying 80 percent.

But if we could come to an understanding, and I think we could, Mr. Chairman, that there is not a great deal of difference as far as the cost of the benefit package is concerned, even though our plan is more comprehensive in scope, and covers the catastrophic illness because we do not have the 60-day limitation that is contained in the committee bill, if we could reach this understanding, then you are faced with the fact that as far as the benefit package is concerned, there will be no substantial difference in the premium that will be required to provide the combined package of the committee bill or the package in the substitute bill. If we could get an agreement on that point, then I think we could proceed with the understanding as to why the difference.

In the first place, since the committee bill provides a higher ratio of Government subsidy—and let me make this clear, both proposals provide a governmental subsidy—but the Government's subsidy under the committee bill is a higher percent of the total cost than the subsidy provided by the substitute bill. Why? Because the hospitalization package in the committee bill is subsidized 100 percent. It is financed by the payroll tax on today's worker to pay 100 percent of the cost of the benefit for today's retired people, namely those over 65 drawing benefits. For the supplemental insurance the committee bill provides a 50-percent subsidy. But when you combine the two, the basic subsidy in the committee bill is higher—substantially higher—than the basic subsidy in the substitute bill.

As I said in my remarks yesterday which appear in the CONGRESSIONAL RECORD, under the committee bill the Government subsidy represents about five-sixths of the cost in those instances where the individual takes the voluntary program in addition to the compulsory hospitalization program. In other words, if the individual takes the full package of benefits provided by the committee bill, the Government pays five-sixths of the cost of that policy.

Under the substitute proposal I will offer, the Government subsidy is about two-thirds or four-sixths of the cost of the benefit package. That is one of the reasons why it costs the Government less. It cannot help but be less costly. The degree of subsidization is lower. In other words, there is a difference of about 16 percent in the amount of the subsidy as between the two bills.

And, let us remember this always—the proposal that will be offered in the motion to recommit is a voluntary proposal. My difference with the committee in this matter was not solely the matter of financing. That is the important difference—financing through a payroll tax as opposed to financing through the general funds on an ability to pay basis.

But there is also a very serious distinction in the matter of whether the program should be voluntary or wheth-

er it should be compulsory. I say it should be voluntary; that those who have satisfactory coverage from other sources should not automatically be blanketed in. We should make the health insurance available to everybody over age 65—without discrimination—which the committee bill does not do, and I believe it should be made available to everybody without discrimination. But let the individual make the basic choice as to whether he wants the insurance.

Now how many will participate under the bill I offer? It is acknowledged that you would not have 100-percent participation because you have people who already have adequate protection at no expense to them. You have, for instance, the automobile workers who have policies furnished by their employers. You have others. You have those who are opposed to the idea of insurance or to medical practice. They would not necessarily desire to be covered and they need not be covered. I use the same assumption that is used by the committee with respect to participation under the voluntary proposal in the committee bill—which they recognize as profitable—participation would be somewhere between 80 and 95 percent. Using that same assumption, we must recognize that we would not have 100 percent and that our participation probably would be within the same range.

Mr. Chairman, as we reason together, let us just recognize when we get to the fundamentals involved that this is a subsidized policy that is being offered. For those people who do not elect to participate, there is a saving to the Government as compared to what the cost would be on the basis of a 100-percent participation. The committee bill does not have this saving as far as its fundamental basic program is concerned. It automatically attains a 100-percent participation. There can be no savings because there is no election.

Since our whole program is voluntary, for every person who does not elect to participate there is a saving. For each of those we save the amount of the Federal subsidy for that individual policy. There is the difference in cost.

I do not see how anybody can have any difficulty in understanding how we can offer a more comprehensive package and do so at a lower cost to the taxpayers because those two factors taken together are bound to give you a reduced cost, and the actuary admits it.

Let me say this, in conclusion, as we come to the end of this debate. I would repeat what I said in opening the debate on yesterday that it is regrettable that this bill could not have been broken up into at least two packages. This is a monumental bill. We all acknowledge that. The chairman acknowledges that it is really four monumental bills in one.

It would only be my hope that we would divide it into two monumental bills, so at least we would have had the chance to vote intelligently on those sections which have to do with the basic social security system, the old age and survivors and disability insurance system, and let the House work its will on

the medical aspects of the program. There is no difference fundamentally so far as the need and the advisability of the basic social security amendments that are contained in those sections of the bill. The difference is only in the medical aspect and fundamentally, Mr. Chairman, I cannot quarrel with you on the voluntary part of that program.

I would have great difficulty voting against it, because it accepts the basic fundamental premise of the bill I proposed earlier this year, which is contained in the substitute to be offered in the motion to recommit.

This brings me to the compulsory hospitalization program. Why am I opposed to that? First, because of the compulsion. I think we serve a much better purpose when we move into the health field if we limit ourselves to voluntary contributory programs.

As we further reason together, my major disagreement is with respect to the use of the payroll tax to finance these benefits. I would say to my friend the majority leader, that I do not say the payroll tax is inherently a bad tax. When it is used for the purpose of financing benefits that are wage-related benefits, it is a good and a sound source of raising revenue. Up to this point that is what we have reserved the payroll tax for. We have used it for that purpose, and for that purpose only—for wage-related benefits.

We use the payroll tax to provide unemployment compensation, where the recipient receives a benefit based on his wage record. It is wage related.

We used the payroll tax for the cash benefits of the social security system. How do we figure the cash benefit? The cash benefit a person receives is related to the wages he has earned and on which the tax has been applied.

But now, for the first time, we are departing from that concept, and that is what I warn, is a dangerous departure. Now we are not going to use the payroll tax for a wage-related benefit, but we are going to use it for a fixed service with no relationship to wages at all. The same package of benefits is to be provided no matter what the wage level.

Of course we should not tailor medical benefits to what the wage level of the individual has been. We should have a package that is the same for everybody. But when we do that we should not finance it on a payroll tax which is related to wages. That is the most regressive tax we have. It is a tax, I remind the Members, that applies to the worker the first day he goes to work as a young boy, on the first dollar he earns. There are no exemptions and no deductions. It is a gross income tax on the lowest level of income in our country.

That is what I object to and that is why I say we are making a very serious mistake. I do not object to the payroll tax, but I object to perverting it and using it for a purpose of providing benefits that are not wage related.

I suggest that we have no justification for imposing a liability on today's workers to the degree to the extent that we are under the committee bill through a

regressive tax. We are imposing on today's generation of workers a liability of some \$40 billion as we enact the hospitalization program under the committee bill and say to our older people, "This is yours as a matter of right."

Do we have a right to impose that liability and then say it shall be paid for with a regressive payroll tax? I do not believe we do. If we wish to provide these benefits, we should impose that liability on the country as a whole, and say that the society of the United States should take care of these older people and assume that liability. Then the burden will rest on all of the people, and it will be borne in relation to ability to pay.

That is why, Mr. Chairman, I shall offer a motion to recommit, offering a substitute on a voluntary and contributory basis.

Mr. MILLS. Mr. Chairman, I yield to the gentleman from Louisiana, the majority whip [Mr. Boggs] 10 minutes.

Mr. BOGGS. Mr. Chairman and Members of the Committee, we have come to the end of truly a historic debate. It has been, as many Members have said heretofore, a very good debate on both sides of the aisle, and on both sides of the aisle there has been recognition of the truly phenomenal job performed by the great chairman of the Committee on Ways and Means, the gentleman from Arkansas [Mr. MILLS]. I have served on this committee for many years now, and I have followed this particular legislation with tremendous interest, because I do not think that there is anything we will do here this year or, for that matter, within this generation, of more importance than what we are about to do now. I must say to you, Mr. Chairman, that there has never been a more thorough, a more conscientious job done than has been done by the Committee on Ways and Means under the direction of the gentleman from Arkansas [Mr. MILLS].

As we come to the end of the debate, let me try, if I can, to put in perspective what we are about to vote on. At the outset, social security is a part of our economy today. Now, it was not always so. Thirty years ago—and I say this without any reflection upon anybody, because one of the great privileges of being an American and the high privilege of being in this body is the right to disagree—in 1935, when this monumental piece of legislation had its inception there was vast disagreement over it among my Republican colleagues. Whereas today I hear expressions about the validity of the payroll tax, at that time it was described by some as dictatorship, socialism, the chaining of the American society and the American economy. Today, however, everyone recognizes that in this society of ours, which is becoming increasingly urbanized, where we have become more and more interdependent upon one another, that the social security system is absolutely essential to the people of our country and to the economy of our country. Today we have 94 million people insured under the program. We have 20 million people drawing social security benefits in the United States today.

Now we have something like 9 out of every 10 people who reach the age of 65 who are qualified for social security benefits.

Now with H.R. 6675 we come to another milestone in this program. Let me try, if I may, to answer just a few arguments which have been advanced here. No. 1, I have not heard very much talk today, by anyone who studied this legislation, about socialized medicine. I can remember for 15 years every time we had a piece of legislation that sought to do something in this area we heard "socialized medicine." We do not hear that on this floor today, and I can tell you the reason why. I mean, we do not hear it from Members of this body who have studied this matter and who are familiar with what is being debated here. The reason is that these bills, the bill from the committee and the substitute offered by our distinguished friend and able colleague from Wisconsin, Mr. BYRNES, insofar as the medical profession is concerned, are almost identical. There is no difference from their point of view. And I might say that under each proposal there is no compulsion of any kind, either involving the medical profession in the practice of medicine or in the historic doctor-patient relationship throughout our country. I might say in passing that in recent campaigns I have had some friends of mine in the profession, who were misinformed—let me put it that way—who fought me rather vigorously. I never engaged in a counteroffensive against this great profession. I know of no finer men individually than members of the medical profession. I took the position that I was not an expert on how to operate on a patient or how to treat an illness and by the same token some public relations firm was not an expert on how to draft or pass legislation or on what ought to be in the legislation.

And I predict that within a relatively short period of time, as the medical profession understands this bill, it will become not only acceptable to the profession but very popular, indeed, with the profession.

Nobody on the Democratic side of the aisle, despite the heat of campaigns, in my judgment, has ever engaged in any controversy with the American Medical Association or with any members of the medical profession. I have a profound respect for the American medical profession. I do not think there is any profession in the world comparable to it in the advances it has made for the benefit of all of our people. This is a tribute that it deserves, and we want it to continue in that tradition.

Let us look at the bill and let us see what is really before us. There is no question about socialized medicine. Let us get that out of our minds. As a matter of fact, the program advanced and advocated by the American Medical Association, as advertised by the public relations firm, was critical of the bill before our committee, H.R. 1, because they said it did not do enough, not that it did too much. I saw some advertisements on television and in the news-

papers where they had checkmarks—"check off here"—and they said, "This is what we do under our proposal and this is what the King bill fails to do." They had boxes checked off.

Then my dear friends on the minority side quite properly said, "We must make recommendations in this field," and they came up with a program which is essentially the motion to recommit on which you will be called upon to vote in a matter of a few minutes.

Let me try to analyze these two proposals. First let us analyze them from the historic concept of social security. What is that concept? Well, it is the insurance concept. I buy insurance and you buy insurance; and I hope I never will have to use it. I have insurance on my house, on my automobile, on my life. I hope none of them will ever have to be used; of course, I know at least one of them will be. The man who insures his house pays for the insurance of the man whose house is destroyed. The whole theory of insurance is that you spread the risk.

Historically, when we adopted social security we had this basic argument. We had people come in and say, "Take the money out of the general fund and let the county and the State and the municipality run these programs on a welfare basis." We said, "No, the American worker, the American businessman, ultimately the American professional man—practically everyone is covered now—has the right to participate in the program."

The CHAIRMAN. The time of the gentleman from Louisiana has expired. Mr. MILLS. Mr. Chairman, I yield the gentleman 5 additional minutes.

Mr. BOGGS. Then, Mr. Chairman, we had advocates of various proposals here when I first came to Congress—we had a petition filed here on the Speaker's desk every year to discharge the Townsend bill, for example.

Now, Mr. Chairman, the Townsend bill was a general pension paid out of the general revenues of the Government of the United States. They had steering committees for the Townsend plan, and so on.

The reason you do not hear about the Townsend plan any more is because the social security program founded on insurance principles has filled that gap.

Now, Mr. Chairman, let us see what is the more fiscally responsible proposition, whether you pay for it on a payroll basis as you go along in an orderly fashion or whether you pay for it out of the general fund of the United States.

Now, Mr. Chairman, the proposal of the Townsendites was that you pay for it out of the general fund of the United States. I must say that the proposal which has been offered by my distinguished friend, the gentleman from Wisconsin [Mr. BYRNES] is based on just exactly the same concept. Somehow or other the impression has been left here that you are going to get the Byrnes proposal for nothing.

Well, let me give you the figures. Incidentally, the discussion that the gentleman made here a moment ago about cost, I am not going to try to go into it, but if you will take a look at the RECORD

for yesterday on page 6955 and on page 6971, you will find that the distinguished chairman of the committee, the gentleman from Arkansas [Mr. MILLS], put all of these figures into the RECORD. What happened was that we had three estimates of the cost. We had a high estimate which was considered the maximum, we had an intermediate estimate which was neither high nor low, and we had a low estimate.

Incidentally, the gentleman from Wisconsin referred to two different recent estimates, one dated April 5 and the other dated April 8. The only difference in those two estimates is that the later one is based on the average contribution from the participants of \$6.50 per month, as stated frequently by the gentleman from Wisconsin, whereas the earlier one used a figure of \$6 which is believed to be a better figure.

Mr. Chairman, what did we do? We took the highest estimate, because we wanted the system to be completely actuarially sound so there would not be a deficit in the trust fund created under this proposal.

So, Mr. Chairman, if you want to talk about fiscal responsibility, if you want to be against deficit financing, if you believe in the pay-as-you-go principle, then you will vote for the committee bill and you will vote against the substitute.

Now, let us talk about what happens as the taxpayer is concerned. He has been talked about here a great deal yesterday and today, and properly so.

Let me give you the cost figures.

The best estimates that we have are that the Byrnes proposal will cost \$4.08 billion per annum. Now, that will be paid for with \$2.75 billion out of the general fund of the Treasury of the United States. I hope that you heard that figure, \$2.75 billion.

Now, let us transfer that again in terms of what the recipient pays for it, as to whether or not he himself is going to be better pleased with this plan.

Aside from what he pays in higher income taxes to finance the general revenues, he would also pay according to Mr. BYRNES, when he reached the age of 65, \$6.50 per month under the voluntary plan; whereas, under the committee supplementary plan he would pay \$3, or he would pay under the Byrnes plan over twice as much as he would pay under the committee plan.

Now, Mr. Chairman, under the Mills plan, under the committee plan, \$2.3 billion will be financed by a payroll tax.

But let us translate this into terms of percentages of payroll. Remember, we are talking about millions and millions and millions of people, so that we spread this risk across the Nation.

What does the hospital insurance tax actually amount to as far as the worker is concerned? In 1966 it will amount to .35 percent, translated into terms of dollars of \$1.63 a month if he earns the maximum amount. In 1987 and thereafter—this is a few years down the road—our best estimates show that the tax will be .80 percent, still less than 1 percent on the worker.

The CHAIRMAN. The time of the gentleman from Louisiana has expired.

Mr. MILLS. Mr. Chairman, I yield the gentleman 5 additional minutes.

Mr. McCORMACK. Mr. Chairman, will the gentleman yield?

Mr. BOGGS. I will be happy to yield to our distinguished Speaker.

Mr. McCORMACK. Mr. Chairman, we are coming to the close of a dramatic and historic debate. In this Chamber within the past 10 days we have seen the elementary and secondary school education bill, which was a historic measure, passed. Today we are concluding another historic debate.

I can remember over 30 years ago, reference having been made by a number of speakers to the original Social Security Act, when I was one of the members of the Committee on Ways and Means that drafted the original Social Security Act. I can remember the opposition on that occasion, and the difficulty we had in getting a bill through.

We are now debating this bill today. It is constructive democracy in dynamic action in accordance with the economic conditions that exist today, and will confront our people in the decades that lie ahead.

We have two bills, one the committee bill, which has been well considered for many years under the able and brilliant leadership of the gentleman from Arkansas, which as it came out of the committee contains a comprehensive plan, joining with him and the other members of the committee, and countless talented persons throughout the country in bringing about this contribution. It is a fiscally responsible bill. The substitute represents fiscal irresponsibility.

In voting for the substitute bill, those who vote for it are voting for a measure that will bring about fiscal irresponsibility as compared with the bill reported out by the committee, and now before the House.

I heartily favor and support the bill reported by the committee, and I hope that the substitute offered by the gentleman from Wisconsin [Mr. BYRNES] will be defeated. In passing the committee bill we will make another historic contribution in the course of the consideration of this great body.

Mr. BOGGS. Mr. Chairman, let me say in conclusion that the Speaker has succinctly defined the issue as far as the substitute is concerned. The substitute in essence says that we would take \$2.75 billion out of the general fund of the United States. My Republican colleagues have always pointed with considerable alarm to the deficit position of the Treasury, but now they would increase that deficit position by \$2.75 billion. In the process, the committee bill, in fact, will certainly make it possible for the American worker to have an insurance program which he so desperately needs in this area as well as in the area in which he is already protected.

Mr. Chairman, I have the great honor and high responsibility, as Speaker Rayburn used to say, of having served in this body for well over 20 years—I do not know of any piece of legislation involving the people of the United States that I consider more important, in the years I have been here, than this pending leg-

isolation. For me this is going to be a proud and happy vote to cast, because I know when this becomes the law of the land it will do more to lift the burdens off the old people in our country, whose numbers are increasing twofold every decade, and more to help the young people who themselves are struggling to rear, house, educate, and take care of growing families and at the same time care for aged parents.

I hope the substitute will be rejected, and that this body will pass the committee bill by an overwhelming majority.

Mr. MILLS. Mr. Chairman, that concludes the general debate.

The CHAIRMAN. Does the gentleman from Wisconsin have any further requests for time?

Mr. BYRNES of Wisconsin. I have no further requests for time, Mr. Chairman.

The CHAIRMAN. Under the rule, the bill is considered as having been read for amendment.

No amendment shall be in order to the bill except amendments offered by direction of the Committee on Ways and Means.

Are there any committee amendments?

Mr. MILLS. There are no committee amendments, Mr. Chairman.

The CHAIRMAN. Under the rule, the Committee rises.

Accordingly the Committee rose; and the Speaker having resumed the chair, Mr. DINGELL, Chairman of the Committee of the Whole House on the State of the Union, reported that that Committee, having had under consideration the bill (H.R. 6675) to provide a hospital insurance program for the aged under the Social Security Act with a supplementary health benefits program and an expanded program of medical assistance, to increase benefits under the old-age, survivors, and disability insurance system, to improve the Federal-State public assistance programs, and for other purposes, pursuant to House Resolution 322, he reported the bill back to the House.

The SPEAKER. Under the rule, the previous question is ordered.

The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

Mr. BYRNES of Wisconsin. Mr. Speaker, I offer a motion to recommit.

The SPEAKER. Is the gentleman opposed to the bill?

Mr. BYRNES of Wisconsin. I am, Mr. Speaker, in its present form.

The SPEAKER. The gentleman qualifies.

The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. BYRNES of Wisconsin moves to recommit the bill (H.R. 6675) to the Committee on Ways and Means, with instructions to report the same back to the House forthwith with the following amendment:

Strike out all after the enacting clause and insert the text of H.R. 7057, with an amendment striking out (in H.R. 7057) line 12 on page 34 and all that follows down through line 24 on page 36 and inserting in lieu thereof the following:

"PAYMENT OF PREMIUMS

"Deductions from social security benefits; transfers from Federal Old-Age and Survivors Insurance-Trust Fund

"SEC. 119. (a) (1) In the case of an individual who is entitled to a benefit for any month under title II of the Social Security Act, his monthly premium for such month under the insurance program established by this title shall (except as provided in subsection (d)) be collected by deducting the amount of such premium from the amount of such benefit. Such deduction shall be made in such manner, and at such times, as the Secretary shall by regulations prescribe.

"(2) The Secretary of the Treasury shall, from time to time, transfer from the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund to the Comprehensive Health Insurance Fund for the Aged the aggregate amount deducted under this subsection for the period to which such transfer relates from benefits under title II of the Social Security Act which are payable from such trust funds. Such transfer shall be made on the basis of a certification by the Secretary of Health, Education, and Welfare and shall be appropriately adjusted to the extent that prior transfers were too great or too small.

"Deductions from railroad retirement annuities or pensions; transfers from railroad retirement account

"(b) (1) In the case of an individual who is entitled to receive for a month an annuity or pension under the Railroad Retirement Act of 1937, his monthly premium for such month under the insurance program established by this title shall (except as provided in subsection (d)) be collected by deducting the amount of such premium from such annuity or pension. Such deduction shall be made in such manner, and at such times, as the Secretary shall by regulations prescribe after consultation with the Railroad Retirement Board.

"(2) The Secretary of the Treasury shall, from time to time, transfer from the Railroad Retirement Account to the Comprehensive Health Insurance Fund for the Aged the aggregate amount deducted under this subsection for the period to which such transfer relates. Such transfer shall be made on the basis of a certification by the Railroad Retirement Board and shall be appropriately adjusted to the extent that prior transfers were too great or too small.

"Individuals entitled to both social security and railroad retirement benefits

"(c) In the case of an individual who is entitled both to monthly benefits under title II of the Social Security Act and to an annuity or pension under the Railroad Retirement Act of 1937 at the time he enrolls pursuant to section 116 in the insurance program established by this title, subsection (a) shall apply so long as he continues to be entitled both to such benefits and to such annuity or pension. In the case of an individual who becomes entitled both to such benefits and to such annuity or pension after he enrolls pursuant to section 116 in such insurance program, subsection (a) shall apply if the first month for which he was entitled to such benefits was the same as or earlier than the first month for which he was entitled to such annuity or pension, and otherwise subsection (b) shall apply.

"Payment of premiums where benefits are insufficient for deduction

"(d) If an individual to whom subsection (a) or (b) applies estimates that the amount which will be available for deduction under such subsection for any premium payment period will be less than the amount of the

monthly premiums for such period, he may (under regulations prescribed by the Secretary) pay to the Secretary such portion of the monthly premiums for such period as he desires.

"Other individual participants

"(e) In the case of an individual who participates in the insurance program established by this title but with respect to whom neither subsection (a) nor subsection (b) applies, the premiums shall be paid to the Secretary at such times, and in such manner, as the Secretary shall by regulations prescribe.

"Deposit in trust fund

"(f) Amounts paid to the Secretary under subsection (d) or (e) shall be deposited in the Treasury to the credit of the comprehensive health insurance fund for the aged.

"Premiums during waiting period

"(g) In the case of an individual who enrolls pursuant to section 116 in the insurance program established by this title, monthly premiums shall be payable commencing with the month immediately preceding the beginning of his benefit period; except that this subsection shall not apply to (1) any month before 1966, or (2) the month in which the individual attains age 65."

Mr. BYRNES of Wisconsin (interrupting the reading of the motion to recommit). Mr. Speaker, I ask unanimous consent that further reading of the motion to recommit be dispensed with and that it be printed in the Record at this point, inasmuch as it was explained earlier.

The SPEAKER. Is there objection to the request of the gentleman from Wisconsin?

There was no objection.

Mr. MILLS. Mr. Speaker, I move the previous question on the motion to recommit.

The previous question was ordered.

The SPEAKER. The question is on the motion to recommit.

Mr. BYRNES of Wisconsin. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The question was taken; and there were—yeas 191, nays 236, answered "present" 1, not voting 5, as follows:

[Roll No. 70]

YEAS—191

Abbott	Buchanan	Derwinski
Abernethy	Burleson	Devine
Adair	Burton, Utah	Dickinson
Anderson, Ill.	Byrnes, Wis.	Dole
Andrews,	Cahill	Dorn
George W.	Callan	Dowdy
Andrews,	Callaway	Downing
Glenn	Carter	Duncan, Tenn.
Andrews,	Casey	Edwards, Ala.
N. Dak.	Cederberg	Ellsworth
Arends	Chamberlain	Erlenborn
Ashbrook	Chelf	Findley
Ashmore	Clancy	Fisher
Baring	Clausen,	Flynt
Bates	Don H.	Ford, Gerald R.
Battin	Clawson, Del	Fountain
Beckworth	Cleveland	Frelinghuysen
Belcher	Collier	Fulton, Pa.
Bell	Colmer	Fuqua
Bennett	Conable	Gathings
Berry	Conte	Gettys
Betts	Cooley	Goodell
Bolton	Corbett	Griffin
Bonner	Cramer	Gross
Bow	Cunningham	Grover
Bray	Curtin	Gubser
Brook	Curtis	Gurney
Broomfield	Dague	Hagan, Ga.
Brown, Ohio	Davis, Ga.	Haley
Broyhill, N.C.	Davis, Wis.	Hall
Broyhill, Va.	de la Garza	Halleck

Hansen, Idaho
Harsha
Harvey, Ind.
Harvey, Mich.
Hébert
Henderson
Herlong
Hosmer
Hull
Hutchinson
Jarman
Johnson, Pa.
Jonas
King, N.Y.
Kornegay
Kunkel
Laird
Langen
Latta
Lennon
Lipscomb
Long, La.
McClory
McCulloch
McDade
McEwen
McMillan
MacGregor
Marsh
Martin, Ala.
Martin, Mass.
Martin, Nebr.
Mathias
Matthews

May
Michel
Minshall
Mize
Moore
Morse
Morton
Mosher
Natcher
Nelsen
O'Konski
O'Neal, Ga.
Passman
Pelly
Pickle
Poff
Pool
Quie
Quillen
Reid, Ill.
Reifel
Reinecke
Rhodes, Ariz.
Rivers, S.C.
Robison
Rogers, Fla.
Rogers, Tex.
Roudebush
Rumsfeld
Satterfield
Saylor
Schneebell
Scott
Selden

Shriver
Sikes
Skubitz
Smith, Calif.
Smith, N.Y.
Smith, Va.
Springer
Stafford
Stanton
Stephens
Stubblefield
Talcott
Taylor
Teague, Calif.
Thompson, La.
Thomson, Wis.
Tuck
Tupper
Tuten
Utt
Waggonner
Walker, Miss.
Watkins
Watts
Whalley
White, Tex.
Whitener
Whitten
Widnall
Williams
Wilson, Bob
Wyatt
Wydler
Younger

NAYS—236

Adams
Addabbo
Albert
Anderson, Tenn.
Annunzio
Aspinall
Ayres
Bandstra
Barrett
Bingham
Blatnik
Boggs
Boland
Bolling
Brademas
Brooks
Brown, Calif.
Burke
Burton, Calif.
Byrne, Pa.
Cabell
Cameron
Carey
Celler
Clark
Clevenger
Cohelan
Conyers
Corman
Craley
Culver
Daddario
Daniels
Dawson
Delaney
Dent
Denton
Diggs
Dingell
Donohue
Dow
Dulski
Duncan, Oreg.
Dwyer
Dyal
Edmondson
Edwards, Calif.
Evans, Colo.
Everett
Evins, Tenn.
Fallon
Farbstein
Farnsley
Farnum
Fascell
Feighan
Fino
Flood
Fogarty
Foley
Ford
William D. Fraser
Friedel
Fulton, Tenn.
Gallagher
Garmatz
Giaino
Gibbons

Gilbert
Gilligan
Gonzalez
Grabowski
Gray
Green, Oreg.
Green, Pa.
Greigg
Grider
Griffiths
Hagen, Calif.
Halpern
Hamilton
Hanley
Hanna
Hansen, Iowa
Hansen, Wash.
Harris
Hathaway
Hawkins
Hays
Hechler
Helstoski
Hicks
Hollifield
Holland
Horton
Howard
Hungate
Huot
Ichord
Irwin
Jacobs
Jennings
Joelson
Johnson, Calif.
Johnson, Okla.
Jones, Mo.
Karsten
Karth
Kastenmeier
Kee
Keith
Keogh
King, Calif.
King, Utah
Kirwan
Kluczynski
Krebs
Landrum
Leggett
Lindsay
Long, Md.
Love
McCarthy
McDowell
McFall
McGrath
McVicker
Macdonald
Machen
Mackay
Mackie
Madden
Mahon
Matsunaga
Meeds
Miller
Mills

Minish
Mink
Moeller
Monagan
Moorhead
Morgan
Morris
Morrison
Moss
Multer
Murphy, Ill.
Murphy, N.Y.
Murray
Nedzi
Nix
O'Brien
O'Hara, Ill.
O'Hara, Mich.
Olsen, Mont.
Olson, Minn.
O'Neill, Mass.
Ottinger
Patman
Patten
Pepper
Perkins
Philbin
Pike
Pirnie
Poage
Powell
Price
Pucinski
Purcell
Race
Randall
Reid, N.Y.
Resnick
Reuss
Rhodes, Pa.
Rivers, Alaska
Roberts
Rodino
Rogers, Colo.
Ronan
Roncalio
Rooney, N.Y.
Rooney, Pa.
Roosevelt
Rosenthal
Rostenkowski
Roush
Roybal
Ryan
St Germain
St. Onge
Scheuer
Schisler
Schmidhauser
Schweiker
Secrest
Sennar
Shipley
Sickles

Steed
Stratton
Sullivan
Sweeney
Teague, Tex.
Tenzer
Thomas
Thompson, N.J.
Thompson, Tex.
Todd

Trimble
Tunney
Udall
Ullman
Van Deerlin
Vanik
Vigorito
Vivian
Walker, N. Mex.
Weitner

White, Idaho
Willis
Wilson,
Charles H.
Wolf
Wright
Yates
Young
Zablocki

ANSWERED "PRESENT"—1

NOT VOTING—5

Ashley
Baldwin

Jones, Ala.
Mailliard

Toll

So the motion to recommit was rejected.

The Clerk announced the following pairs:

On the vote:

Mr. Mailliard for, with Mr. Ashley against.

Mr. Hardy for, with Mr. Jones of Alabama against.

Mr. HARDY. Mr. Speaker, I have a live pair with the gentleman from Alabama [Mr. JONES]. If he were present he would have voted "nay." I voted "yea." I withdraw my vote and vote "present."

The result of the vote was announced as above recorded.

The SPEAKER. The question is on the passage of the bill.

Mr. MILLS. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The question was taken; and there were—yeas 313, nays 115, not voting 5, as follows:

[Roll No. 71]

YEAS—313

Adams
Addabbo
Albert
Anderson, Tenn.
Annunzio
Aspinall
Ayres
Bandstra
Barrett
Boggs
Boland
Bolling
Bonner
Bow
Brademas
Brooks
Broomfield
Brown, Calif.
Broyhill, N.C.
Burke
Burton, Calif.
Byrne, Pa.
Cahill
Callan
Cameron
Carey
Cederberg
Celler
Chamberlain
Clark
Cleveland
Clevenger
Cohelan
Conable
Conte
Conyers
Corbett
Corman
Craley
Culver
Cunningham
Curtin
Daddario
Dague

Daniels
Dawson
de la Garza
Delaney
Dent
Denton
Diggs
Dingell
Donohue
Dow
Dowdy
Dulski
Duncan, Oreg.
Dwyer
Dyal
Edmondson
Edwards, Calif.
Evans, Colo.
Everett
Evins, Tenn.
Fallon
Farbstein
Farnsley
Farnum
Fascell
Feighan
Fino
Flood
Fogarty
Foley
Ford
William D. Fountain
Fraser
Frelinghuysen
Friedel
Fulton, Pa.
Fulton, Tenn.
Gallagher
Garmatz
Gettys
Giaino
Gibbons
Gilbert
Gilligan
Gonzalez
Goodell
Grabowski
Gray
Green, Oreg.
Green, Pa.
Greigg
Grider

Griffin
Griffiths
Grover
Gubser
Gurney
Hagen, Calif.
Haley
Halpern
Hamilton
Hanley
Hanna
Hansen, Iowa
Hansen, Wash.
Hardy
Harris
Harvey, Mich.
Hathaway
Hawkins
Hays
Hechler
Helstoski
Henderson
Herlong
Hicks
Hollifield
Holland
Horton
Howard
Hull
Hungate
Huot
Hutchinson
Ichord
Irwin
Jacobs
Jennings
Joelson
Johnson, Calif.
Johnson, Okla.
Karsten
Karth
Kastenmeier
Kee
Keith
Kelly
Keogh
King, Calif.
King, N.Y.
King, Utah
Kirwan
Kluczynski
Krebs

Kunkel
Landrum
Leggett
Lindsay
Long, Md.
Love
McCarthy
McClory
McCulloch
McDade
McDowell
McEwen
McFall
McGrath
McVicker
Macdonald
Machen
Mackay
Mackie
Madden
Martin, Mass.
Mathias
Matsunaga
Matthews
Meeds
Miller
Mills
Minish
Mink
Minshall
Moeller
Monagan
Moore
Moorhead
Morgan
Morris
Morrison
Morse
Mosher
Moss
Multer
Murphy, Ill.
Murphy, N.Y.
Murray
Natcher
Nedzi
Nix
O'Brien
O'Hara, Ill.
O'Hara, Mich.
O'Konski
Olsen, Mont.
Olson, Minn.

O'Neill, Mass.
Ottinger
Patman
Patten
Pelly
Pepper
Perkins
Philbin
Pike
Pirnie
Powell
Price
Pucinski
Purcell
Race
Randall
Redlin
Reid, N.Y.
Reifel
Reinecke
Resnick
Reuss
Rhodes, Pa.
Rivers, Alaska
Roberts
Robison
Rodino
Rogers, Colo.
Rogers, Fla.
Rogers, Tex.
Ronan
Roncalio
Rooney, N.Y.
Rooney, Pa.
Roosevelt
Rosenthal
Rostenkowski
Roush
Roybal
Ryan
St Germain
St. Onge
Saylor
Scheuer
Schisler
Schmidhauser
Schneebell
Schweiker
Scott
Secrest
Sennar
Shipley
Sickles

NAYS—115

Abbott
Abernethy
Adair
Anderson, Ill.
Andrews,
George W.
Andrews,
Glenn
Andrews,
N. Dak.
Arends
Ashbrook
Baring
Battin
Belcher
Bell
Bennett
Berry
Betts
Bolton
Bray
Brock
Brown, Ohio
Broyhill, Va.
Buchanan
Burleson
Burton, Utah
Byrnes, Wis.
Cabell
Callaway
Carter
Casey
Clancy
Clausen,
Don H.
Clawson, Del.
Collier
Colmer
Curtis
Davis, Ga.

Davis, Wis.
Derwinski
Devine
Dickinson
Dole
Dorn
Downing
Duncan, Tenn.
Edwards, Ala.
Ellsworth
Erlenborn
Findley
Fisher
Flynt
Ford, Gerald R.
Fuqua
Gathings
Gross
Hagan, Ga.
Hall
Halleck
Hansen, Idaho
Harsha
Harvey, Ind.
Hébert
Hosmer
Jarman
Jonas
Jones, Mo.
Kornegay
Laird
Langen
Latta
Lennon
Lipscomb
Long, La.
McMillan
MacGregor
Mahon
Marsh

Martin, Ala.
Martin, Nebr.
May
Michel
Mize
Morton
Nelsen
O'Neal, Ga.
Passman
Pickle
Poage
Poff
Pool
Quie
Quillen
Reid, Ill.
Rhodes, Ariz.
Rivers, S.C.
Roudebush
Rumsfeld
Satterfield
Selden
Shriver
Skubitz
Smith, Calif.
Smith, Va.
Springer
Steed
Stephens
Teague, Tex.
Thomson, Wis.
Tuck
Utt
Waggonner
Walker, Miss.
Whitten
Williams
Wilson, Bob
Younger

NOT VOTING—5

Ashley
Baldwin

Jones, Ala.
Mailliard

Toll

So the bill was passed.

The Clerk announced the following pairs:

Mr. Toll with Mr. Ashley.

April 8, 1965

CONGRESSIONAL RECORD — HOUSE

7183

The result of the vote was announced
as above recorded.

A motion to reconsider was laid on the
table.

89TH CONGRESS
1ST SESSION

H. R. 6675

IN THE SENATE OF THE UNITED STATES

APRIL 9 (legislative day, APRIL 8), 1965

Read twice and referred to the Committee on Finance

AN ACT

To provide a hospital insurance program for the aged under the Social Security Act with a supplementary health benefits program and an expanded program of medical assistance, to increase benefits under the Old-Age, Survivors, and Disability Insurance System, to improve the Federal-State public assistance programs, and for other purposes.

- 1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 That this Act, with the following table of contents, may be
4 cited as the "Social Security Amendments of 1965".

NOTE: The bill, H.R. 6675, was considered in the House under a closed rule permitting only amendments offered by direction of the Committee on Ways and Means, such amendments not subject to amendment. No amendments were offered and the bill passed the House without amendment as reported by the Ways and Means Committee. Accordingly, the substance of the bill as passed by the House has not been included.

The title page and the final page of the House-passed bill reproduced here show the only changes--identifying information and the signature of the clerk of the House.

1 (2) The heading of section 1112 of such Act is amended
2 by striking out "FOR THE AGED".

3 (1) Section 1115 of such Act is amended by striking
4 out "or XVI", "or 1602", and "or 1603" and inserting in
5 lieu thereof "XVI, or XIX", "1602, or 1902", and "1603,
6 or 1903", respectively.

Passed the House of Representatives April 8, 1965.

Attest:

RALPH R. ROBERTS,

Clerk.

89TH CONGRESS
1ST Session

H. R. 6675

AN ACT

To provide a hospital insurance program for the aged under the Social Security Act with a supplementary health benefits program and an expanded program of medical assistance, to increase benefits under the Old-Age, Survivors, and Disability Insurance System, to improve the Federal-State public assistance programs, and for other purposes.

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